

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

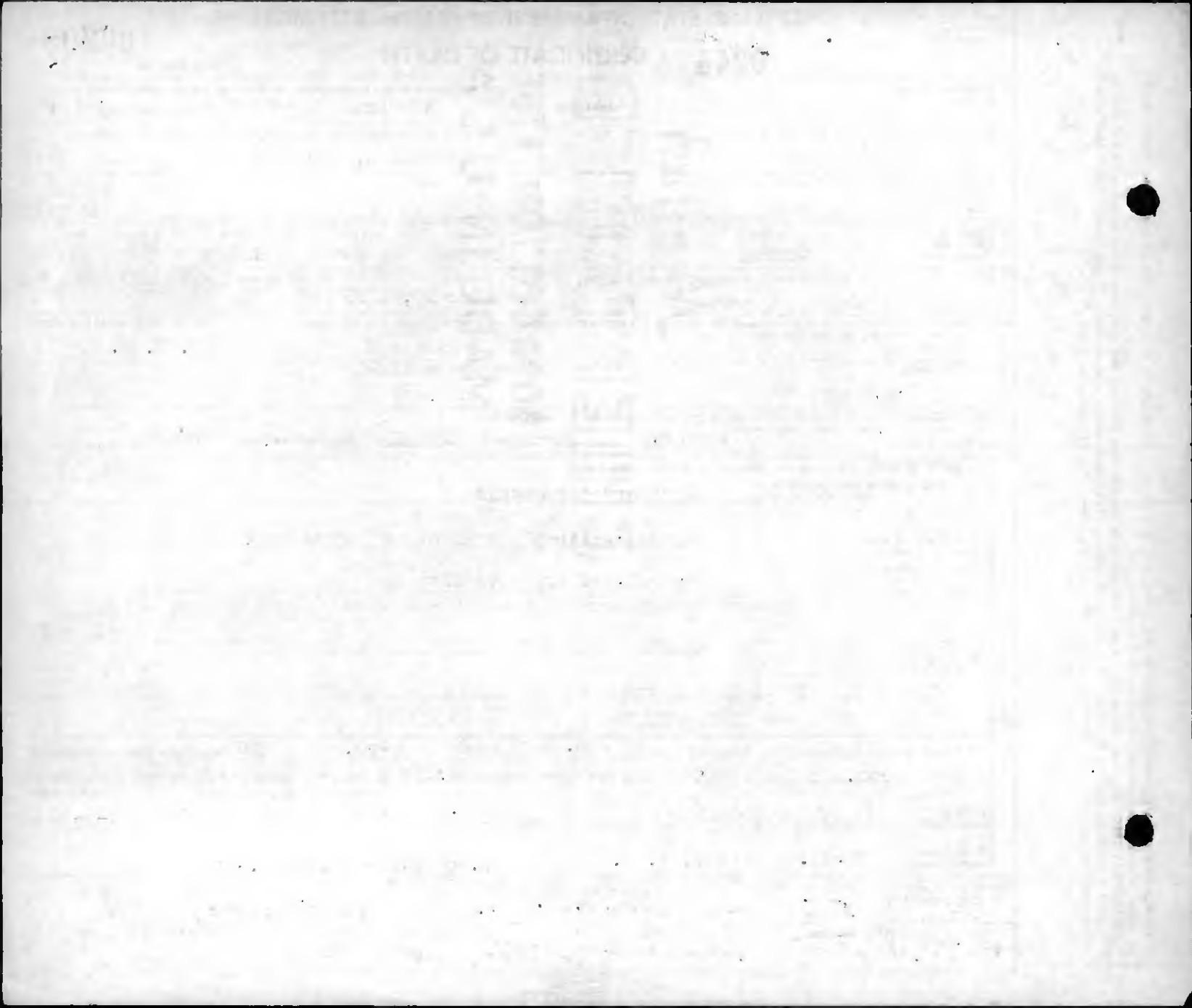
Reg. Dist. No.

00209

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mthl8dys						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First Conrad	Middle	Last Abend					
4. DATE OF DEATH	Month January	Day 5	Year 1960					
S. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 10, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown=		16. SOCIAL SECURITY NO. Unknown	INFORMANT Records: SPRING GROVE STATE HOSPITAL	Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Coronary thrombosis								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease								
DUE TO (c) Generalized arteriosclerosis								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from Jan. 4, 1960, to Jan. 5, 1960, that I last saw the deceased alive on Jan. 5, 1960, and that death occurred at 1:15 p. M. from the causes and on the date stated above.								
ADDRESS (Street, city or town, state)								
DATE SIGNED								
ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 1-5-60								
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 1960		22c. NAME OF CEMETERY OR CREMATORIAL Glen Haven Cem.		22d. LOCATION (City, town, or county) Glen Burnie, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE R. V. Singleton ADDRESS Glen Burnie, Md.								
24a. REC'D BY REGISTRAR DATE JAN 7 '60					24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

**TO HOSPITAL**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retorted by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00210

## 0245 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Catonsville

c. LENGTH OF STAY IN 1b

1mth19dys

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

SPRING GROVE STATE HOSPITAL

3. NAME OF  
DECEASED  
(Type or print)First  
Louis

Middle

Last  
Abraham4. DATE  
OF  
DEATHMonth  
JanuaryDay  
5  
Year  
1960

## 5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

## 8. DATE OF BIRTH

9. AGE (In years  
last birthday)  
76 yrs.

## 10. IF UNDER 1 YEAR

IF UNDER 24 HRS.  
Months Days Hours Min.

male

white

WIDOWED DIVORCED 

Oct. 15, 1883

10a. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

retired - laborer

10b. KIND OF BUSINESS OR INDUSTRY

Balto. City

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U. S. A.

## 13. FATHER'S NAME

Unknown Albin Abraham

## 14. MOTHER'S MAIDEN NAME

Unknown Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(If no, as unknown)  
Unknown no16. SOCIAL SECURITY NO.  
Unknown none

## INFORMANT

Address

Records: SPRING GROVE STATE HOSPITAL

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Arteriosclerotic cardiovascular disease

INTERVAL BETWEEN  
ONSET AND DEATH

422.1

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

Generalized arteriosclerosis

DUE TO

(c)

## PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES  NO 

## MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year  
Hour a. m. p. m. 1920d. INJURY OCCURRED  
While at work  Not while at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec. 30, 1959, to January 5, 1960, that I last saw the deceased alive on January 5, 1960, and that death occurred at P.M., from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Stella Wachsler

M.D.

SPRING GROVE STATE HOSPITAL

1-6-60

PHYSICIAN'S  
NAME (Type)

Stella Wachsler, M. D.

Catonsville 28, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify)  
Burial22b. DATE THEREOF  
1/8/6022c. NAME OF CEMETERY OR CREMATORY  
Balto. Cem.

22d. LOCATION (City, town, or county)

(State)

Balto., Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

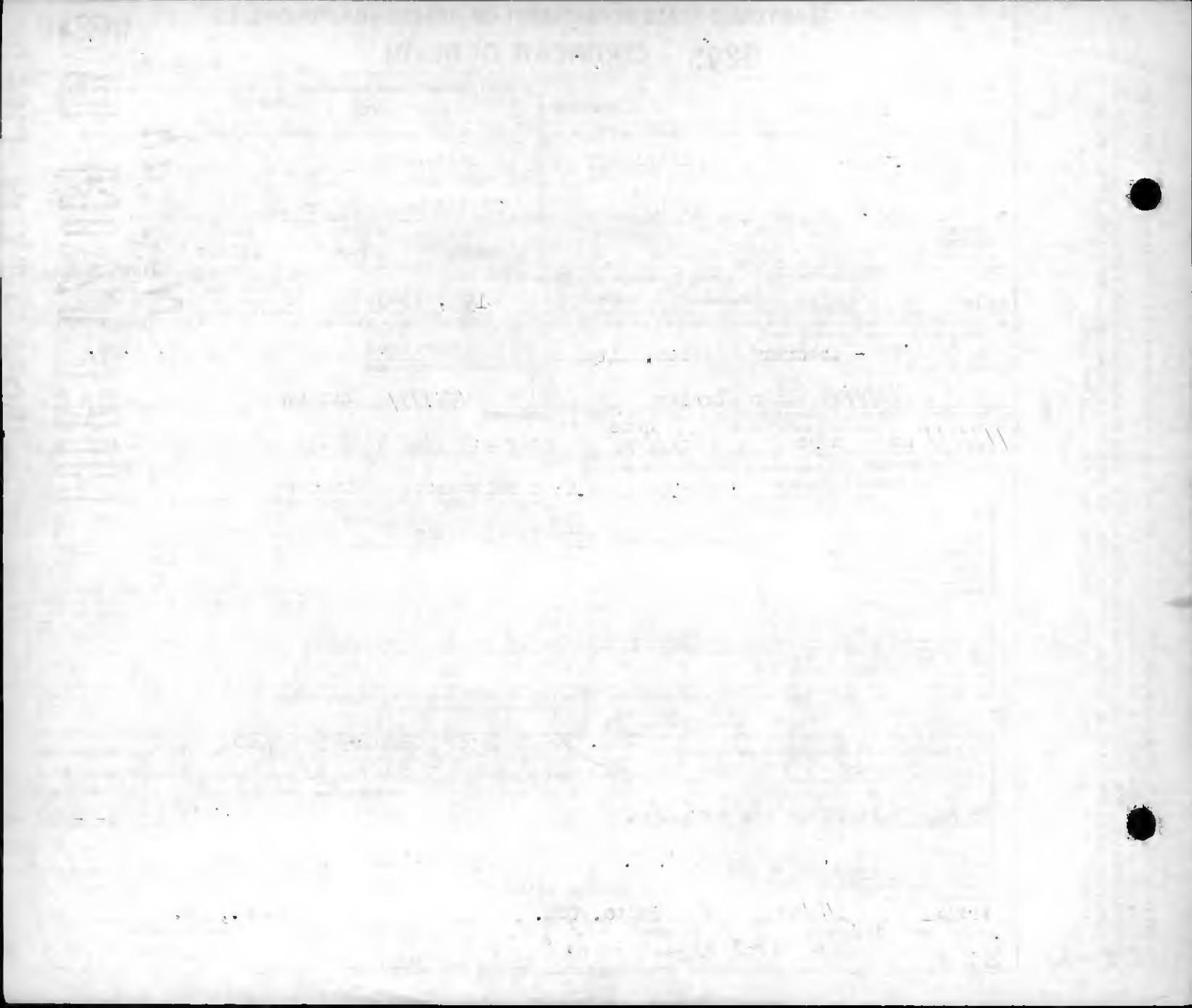
John F. Pickner &amp; Sons - Balto. Md.

24a. REC'D BY REGISTRAR

DATE JAN 7 '60

24b. REGISTRAR'S SIGNATURE

Arthur S. Krause



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0246 CERTIFICATE OF DEATH

00211

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>BALTIMORE</i>		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>CATCHSVILLE</i>		c. LENGTH OF STAY IN TB <i>3 YRS</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>CATONRIDGE HOME</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BALTIMORE</i>	
3. NAME OF DECEASED (Type or print)		First <i>BERTHA</i>	Middle <i>Lou</i>
4. DATE OF DEATH		Month <i>AUG</i>	Day <i>8</i>
5. SEX		6. COLOR OR RACE <i>FEMALE WHITE</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday) <i>90 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>HOUSEKEEPER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i>	11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>ROMA AHL</i>		14. MOTHER'S MAIDEN NAME <i>MARY McCAFFERTY</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>NONE</i>	17. INFORMANT <i>EDITH UEBER 813 N. MONTFORD AVE</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs</i>	
422.1 Conditions, if any, which goes rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Alina Schleske (c) DUE TO Alf -		Cardiac failure	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Note</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Sep 28</i> , 19 <i>62</i> , to <i>1/8</i> , 19 <i>62</i> , that I last saw the deceased alive on <i>1/4</i> , 19 <i>62</i> , and that death occurred at <i>12 AM</i> ; from the causes and on the date stated above. ACTUAL SIGNATURE <i>Cliff Ratliff Jr.</i> M.D. <i>4605 Edmondson Ave</i> DATE SIGNED <i>1/1/60</i>		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>PURINA</i>		22b. DATE THEREOF <i>1-11-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>PARKWOOD</i>
22d. LOCATION (City, town, or county) <i>BALTO. MD.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>FR. CVAUGH &amp; SON 900 N. CHESTER ST</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 11 1960</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECORDED IN THE OFFICE OF THE CLERK OF THE STATE BOARD OF EDUCATION  
AT THE STATE CAPITAL - SALT LAKE CITY

STATE OF UTAH - 1970

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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0247

## CERTIFICATE OF DEATH

Reg. Dist. No.

00212

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>5101 Brookgreen Rd</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Daniel</b>	Middle <b>S.</b>	Last <b>Alder</b>	4. DATE OF DEATH <b>Jan. 28/60</b>	Month <b>Jan.</b>	Day <b>28</b>	Year <b>1960</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 13, 1874</b>	9. AGE (In years last birthday) <b>85</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Patrolman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore City</b>		11. BIRTHPLACE (State or foreign country) <b>Corbett, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>late George Alder</b>				14. MOTHER'S MAIDEN NAME <b>late Anne Ryan</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Newton Alder, 5101 Brookgreen Rd. Zone 29</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>		<b>Coronary Thrombosis, Acute</b>				2 days				
DUE TO										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		<b>Arteriosclerotic Cardio-vascular disease</b>				unknown				
DUE TO										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Left Hemiplegia</b>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>July 19, 58</b> , to <b>Jan. 19, 60</b> , that I last saw the deceased alive on <b>Jan. 27, 1960</b> , and that death occurred at <b>5:30A.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>1 Mallow Hill Ave., Baltimore 29, Md.</b>				DATE SIGNED <b>1/28/60</b>
ACTUAL SIGNATURE <b>Leo J. Gaver</b>										
PHYSICIAN'S NAME (Type) <b>Leo J. Gaver</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 30/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>		22d. LOCATION (City, town, or county) <b>Baltimore 29, Md.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>4101 Edmondson Ave.</b>		ADDRESS				24a. REC'D. BY REGISTRAR <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00213

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>21yr8mth21dsy</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Maryland</b>	
f. STREET ADDRESS <b>308 West Street</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard</b>		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1872</b>
9. AGE (In years (b) birthday) <b>07 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>John R. Arnold</b>		14. MOTHER'S MAIDEN NAME <b>Ruth Armiger</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>902.7</b>		acute Cardiac failure	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Cardio vascular disease	
DUE TO (c)		partured femur accident	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ON 12-6-59 pt. fell while getting out of chair, sustaining a fractured left femur	
20c. TIME OF INJURY Month, Day, Year Hour <b>6:05</b> p.m. 12-6 19 59		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Catonsville</b> (County) <b>28, Maryland</b> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Dr. M. Kieffer</i>		DATE SIGNED <b>1-13-60</b>	
EXAMINER'S NAME (Type) <b>George M. Kieffer, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 15, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Bluff Cemetery</b>		22d. LOCATION (City, town, or county) <b>Annapolis, Maryland</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hopping Funeral Home</i>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hanna</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00214

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-troussal permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cities</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>8058 Milton Ave</i>		e. STREET ADDRESS <i>8058 Milton Ave</i>	
3. NAME OF DECEASED (Type or print) <i>ESTHER</i>		First <i>ASHKENAZY</i>	Last <i>ASHKENAZY</i>
4. DATE OF DEATH Month <i>1</i> Day <i>18</i> Year <i>1960</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <i>65 yrs.</i>		10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	11. IF UNDER 24 HRS
10a. U.S. JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Russia</i>	
11. BIRTHPLACE (State or foreign country) <i>Russia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Samuel</i>		14. MOTHER'S MAIDEN NAME <i>Freida</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. INFORMANT <i>Eva Adler - same</i>	
17. Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>163x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>25 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>Hypertension Cardiac Hypertrophy</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>4200</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>1950</i> , to <i>1960</i> , that I last saw the deceased alive on <i>1-10</i> , 19 <i>60</i> , and that death occurred at <i>4200</i> M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) <i>5320 Park Heights Ave. Baltimore - 15 Md.</i>	
ACTUAL SIGNATURE <i>Theodore Cooper MD</i>		DATE SIGNED <i>1/18/60</i>	
PHYSICIAN'S NAME (Type) <i>Theodore Cooper M.D.</i>			
22a. BURIAL CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1-19-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Carmel</i>
22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc 2000 Eutaw Place</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 19 60</i>	24b. REGISTRAR'S SIGNATURE <i>J. Lewis</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0211 CERTIFICATE OF DEATH

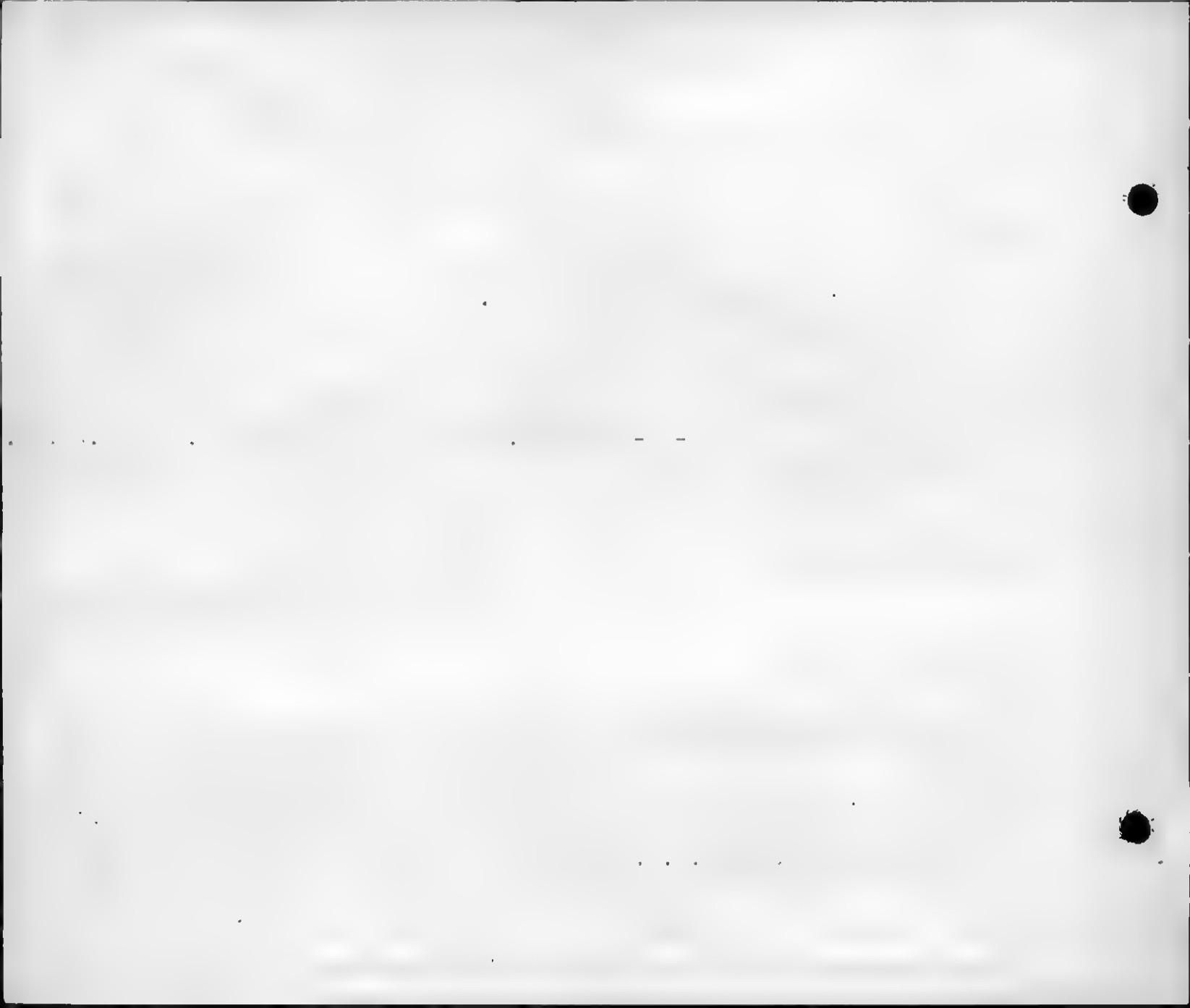
Reg. Dist. No.

00215

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>98 Kentway</b>		d. STREET ADDRESS <b>98 Kentway</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Alice Abegail Ashley</b>		First <b>Alice</b>	Middle <b>Abegail</b>
4. DATE OF DEATH		Month <b>January</b>	Day Year <b>25th, 1960</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Feb. 12, 1875</b>		9. AGE (In years less birthday) <b>84</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Williard F. Rowe</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>190-01-9817</b>	17. INFORMANT <b>Wm. Ashley, 7008 Dunbar Rd., Balto. 22, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		Address <b>INTERVAL BETWEEN ONSET AND DEATH 10 days</b>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Particulars</b>			
(b) DUE TO <b>Particulars</b>			
(c) DUE TO <b>Particulars</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Particulars</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Particulars</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Particulars</b>
20f. (City or town) <b>Particulars</b>		(County) <b>Particulars</b> (State) <b>Particulars</b>	
21. I certify that I attended the deceased from <b>Particulars</b> , 19 <b>58</b> to <b>Particulars</b> , 19 <b>62</b> , that I last saw the deceased alive on <b>Particulars</b> , 19 <b>62</b> , and that death occurred at <b>Particulars</b> , M, from the causes and on the date stated above. <b>Particulars</b>		ADDRESS (Street, city or town, state) <b>Particulars</b> DATE SIGNED <b>Particulars</b> <b>1/26/60</b>	
ACTUAL SIGNATURE <b>Particulars</b>		PHYSICIAN'S NAME (Type) <b>Melvin B. Davis, M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Mount Airy Cemetery</b>
22d. LOCATION (City, town, or county) <b>Birdsville, Pennsylvania</b>		(State) <b>Particulars</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradbury Jr.</b>		ADDRESS <b>Dundalk 22, Md.</b>	24a. REC'D BY REGISTRAR <b>DEAN 28 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00216

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		0249		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission)	
Baltimore MARYLAND				a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 100 son 1 yr 4 mo		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore -18 5 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sheppard Pratt Hosp.		d. STREET ADDRESS 3501 St Paul St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Avery Atkinson		First	Middle	4. DATE OF DEATH Jan 24	Month Year 1960
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 26, 1877	9. AGE (in years less birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) California	
13. FATHER'S NAME Thomas Atkinson		14. MOTHER'S MAIDEN NAME Sally Turgen		12. CITIZEN OF WHAT COUNTRY U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? No		16. SOCIAL SECURITY NO 070-14-3476		17. INFORMANT Hosp. Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial pneumonia</u> DUE TO <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic myocarditis</u> DUE TO <u>Chronic bronchitis</u> (c) <u>Generalized arteriosclerosis</u>					
INTERVAL BETWEEN ONSET AND DEATH 3 da					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <u>Chronic Bronch Syndrome</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 10</u> , 1958, to <u>Jan 24</u> , 1960, that I last saw the deceased alive on <u>Jan 23</u> , 1960, and that death occurred at <u>8:15 AM</u> , from the causes and on the date stated above					
ADDRESS (Street, city or town, state) <u>Sheppard Pratt Hosp.</u> DATE SIGNED <u>1/24/60</u>					
ACTUAL SIGNATURE <u>H.W. Elgin</u>					
PHYSICIAN'S NAME (Type) <u>W.W. Elgin</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>1/27/60</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Methodist Episcopal Church Cemetery</u>	
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry D. Jenkins, York Rd., Bell, Md.</u>		ADDRESS <u>Henry D. Jenkins, York Rd., Bell, Md.</u>		24a. RECD BY REGISTRAR DATE JAN 25 '60	
				24b. REGISTRAR'S SIGNATURE <u>Elmer S. Martin</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

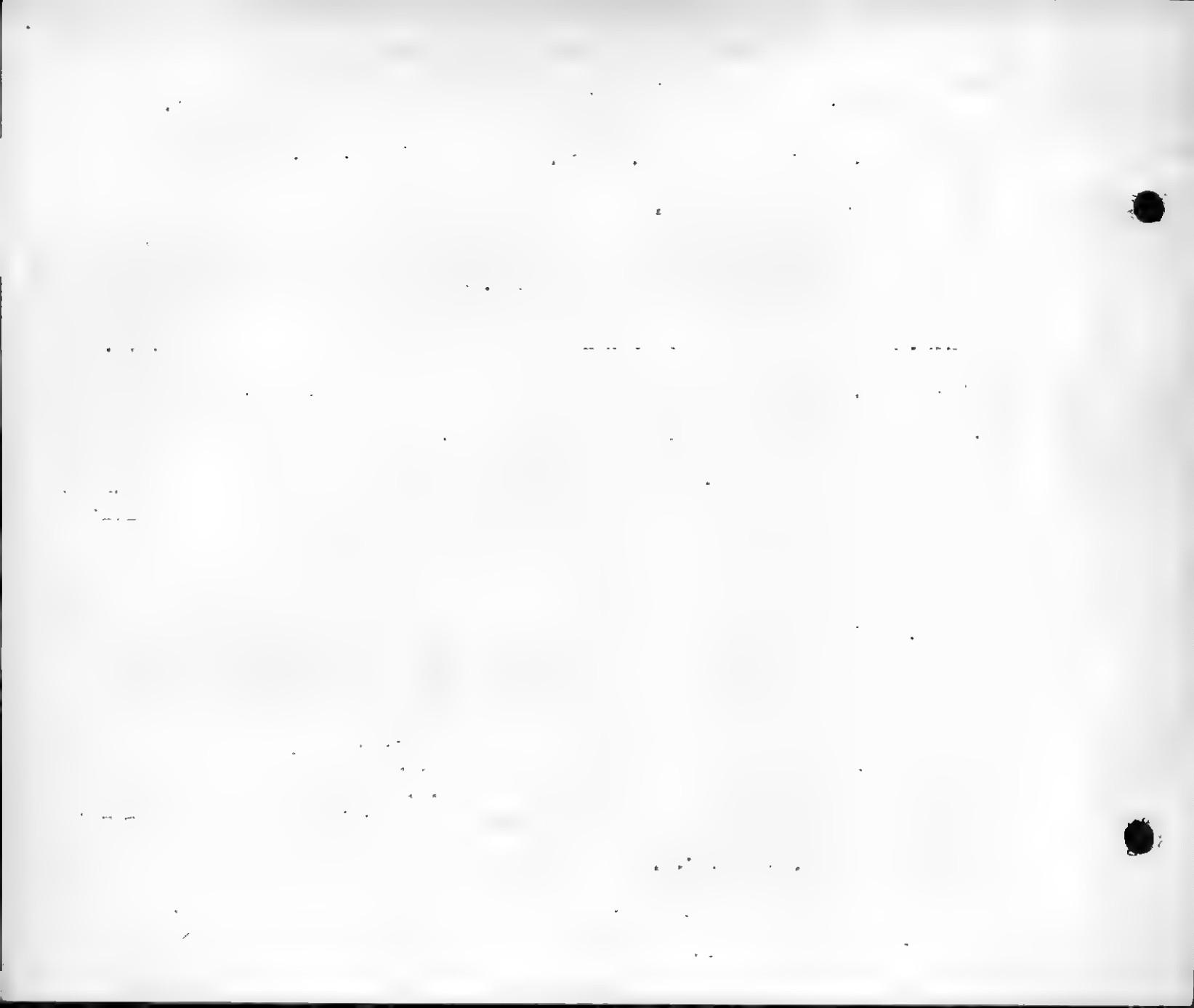


MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0250 CERTIFICATE OF DEATH

00217

Reg. Dist. No.

1		TO HOSPITAL, by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.		Page 4	
1		PLACE OF DEATH a. COUNTY Rosewood State Training School Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
2		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		b. COUNTY Baltimore ✓	
3		c. LENGTH OF STAY IN 1b 2 yrs. 3 mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Lutherville, Maryland	
4		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		d. STREET ADDRESS 510 Spring Avenue	
5		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
6		3. NAME OF DECEASED (Type or print) Kathleen		First Middle Last	
7		4. DATE OF DEATH		Month Day Year	
8		5. SEX Female		January 7 19 60	
9		6. COLOR OR RACE White		5. SEX Female	
10		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/21/57	
11		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 492X		10b. KIND OF BUSINESS OR INDUSTRY -----	
12		11 BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13		13. FATHER'S NAME Francis R. Baake		14. MOTHER'S MAIDEN NAME Eileen Marie Kostkos Baake	
15		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17		17. INFORMANT Rosewood Records		Address	
18		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Pneumonitis 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 1-4-60 - 1-7-60	
20		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Mongolism		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22		20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
23		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
24		21. I certify that I attended the deceased from December 24, 19 59, to January 7, 19 60 that I last saw the deceased alive on January 7, 19 60, and that death occurred at 12:30 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Viola B. Johns</i>		DATE SIGNED 1-7-60	
25		M.D. ADDRESS (Street, city or town, state)			
26		PHYSICIAN'S NAME (Type) Viola B. Johns, M.D.			
27		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-8-60	
28		22c. NAME OF CEMETERY OR CREMATORIAL Prospect Hill		22d. LOCATION (City, town, or county) Towson 4, Md. (State)	
29		23. FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		24a. REC'D BY REGISTRAR DATE JAN 11 '60	
30		ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Charles S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0251 CERTIFICATE OF DEATH

Reg. Dist. No.

00218

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Pikesville X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION House in The Pines		d. STREET ADDRESS Greenspring Avenue #8	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			

3. NAME OF DECEASED (Type or print)		First CECILE	Middle H.	Last BAER	4. DATE OF DEATH Jan. 20 1960
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH May 26, 1915	9. AGE (in years lost birthday) 44 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME Jessie Heineman	14. MOTHER'S MAIDEN NAME Eva Morris
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	16. SOCIAL SECURITY NO. 216-10-4536	17. INFORMANT Mr. Irvin C. Baer - Greenspring Avenue #8	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH 3 mo.
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Borders-Premises</i>		
334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Cerebral Anoxemia, Cortical Degeneration</i> DUE TO		
(c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that I attended the deceased from <u>10-2-</u> , 19 <u>59</u> , to <u>1-20-1960</u> , that I last saw the deceased alive on <u>1-19-</u> , 19 <u>60</u> , and that death occurred at <u>7-451</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED <u>1-21-60</u>
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ACTUAL SIGNATURE <i>Walter K. Gallagher</i>	M.D. <i>6209 Frederick Road</i>
--	---------------------------------

PHYSICIAN'S NAME (Type) <i>Walter K. Gallagher</i>	Baltimore 28, Md.
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22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	22b. DATE THEREOF 1/21/60	22c. NAME OF CEMETERY OR CREMATORIAL Greenmount Crematory	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
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23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Tucker &amp; Sons</i>	ADDRESS <i>Baltimore 12, Md.</i>	24a. REC'D BY REGISTRAR DATE JAN 22 '60	24b. REGISTRAR'S SIGNATURE <i>John S. Kline</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0252

## CERTIFICATE OF DEATH

Reg. Dist. No.

00219

## 1. PLACE OF DEATH

a. COUNTY

Baltimore County

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

c. LENGTH OF STAY IN 1b  
RURAL and give nearest town)

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Mercy Villa

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Baltimore

3vo 1 +

d. STREET ADDRESS

3601 Greenway

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Jan.

13,

1960

5. SEX

6. COLOR OR RACE

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

9. AGE (in years  
at birthday)

yrs.

10. IF UNDER 1 YEAR

IF UNDER 24 HRS

Months

Days

Hours

Min.

Female

White

WIDOWED DIVORCED 

June 24, 1876

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Henry S. Zell

14. MOTHER'S MAIDEN NAME

Katharine Caughy

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown)

(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

INFORMANT

C. C. Grasty

Address

13 South Street

## 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

420.0

DUE TO

Arteriosclerotic Heart Disease

INTERVAL BETWEEN  
ONSET AND DEATH

4 months

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

Congestive heart failure

(c)

8 weeks

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

MEDICAL CERTIFICATION

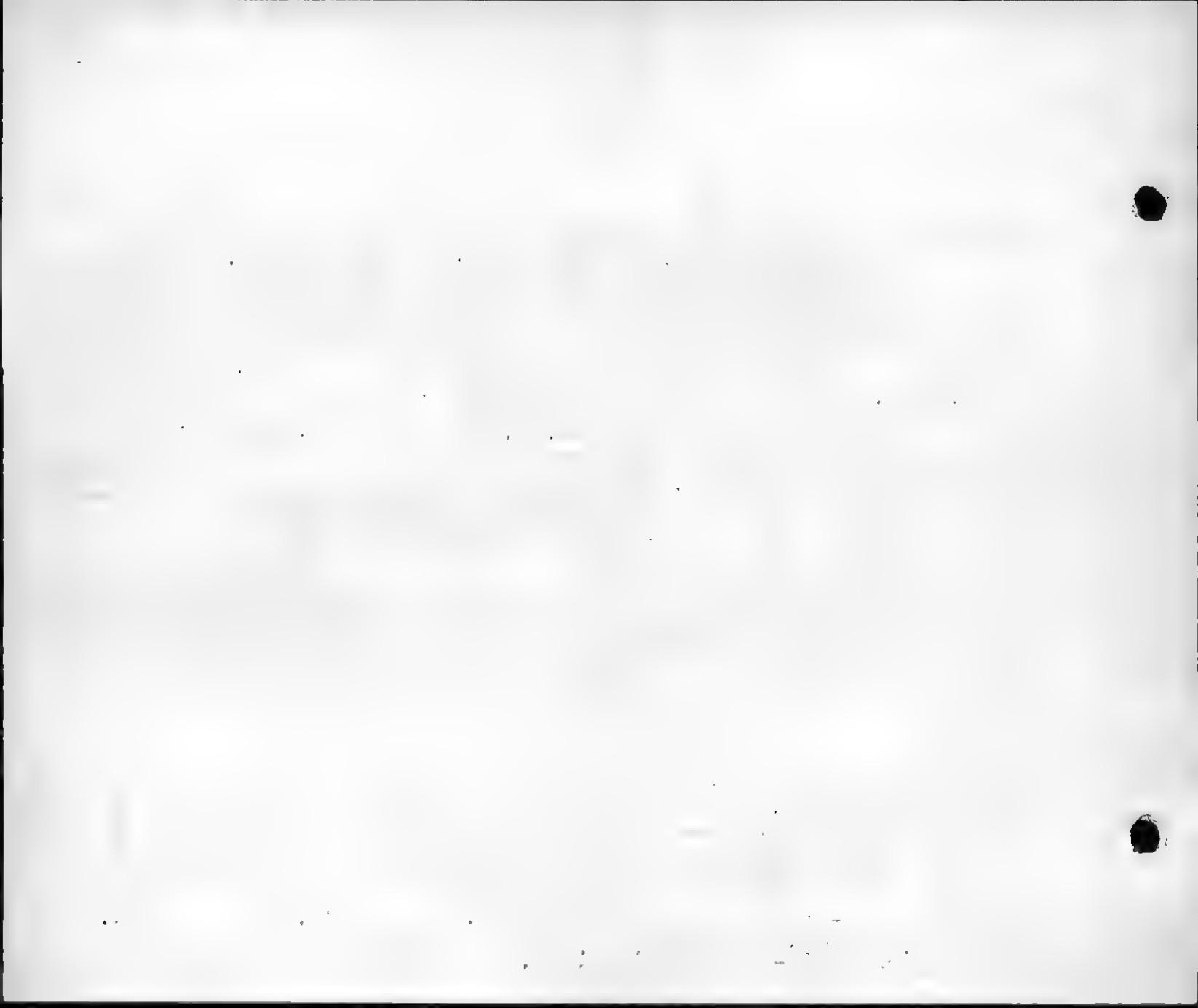
20c. TIME OF INJURY	Month.	Day.	Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
Hour p. m.	19			While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>				

21. I certify that I attended the deceased from June 1, 1953, to Jan. 13, 1960, that I last saw the deceased alive on Jan. 13, 1960, and that death occurred at 10:02 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE *Crawford N. Kirkpatrick, Jr.* M.D. 6 E. Eager St., Baltimore 2, Md. Jan. 13, 1960PHYSICIAN'S  
NAME (Type) *CRAWFORD N. KIRKPATRICK, JR.*22a. BURIAL, CREMATION  
REMOVAL (Specify) *Burial* 22b. DATE THEREOF *1-16-60* 22c. NAME OF CEMETERY OR CREMATORIUM *Loudon Park Cem.* 22d. LOCATION (City, town, or county) (State) *Balto.* Md.23. FUNERAL DIRECTOR'S SIGNATURE *Henry W. Jenkins & Sons Co. Inc.* ADDRESS *4905 York Road - Baltimore 12, Md.* 24a. REC'D BY REGISTRAR *JAN 15 '60* 24b. REGISTRAR'S SIGNATURE *Arthur S. Evans*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

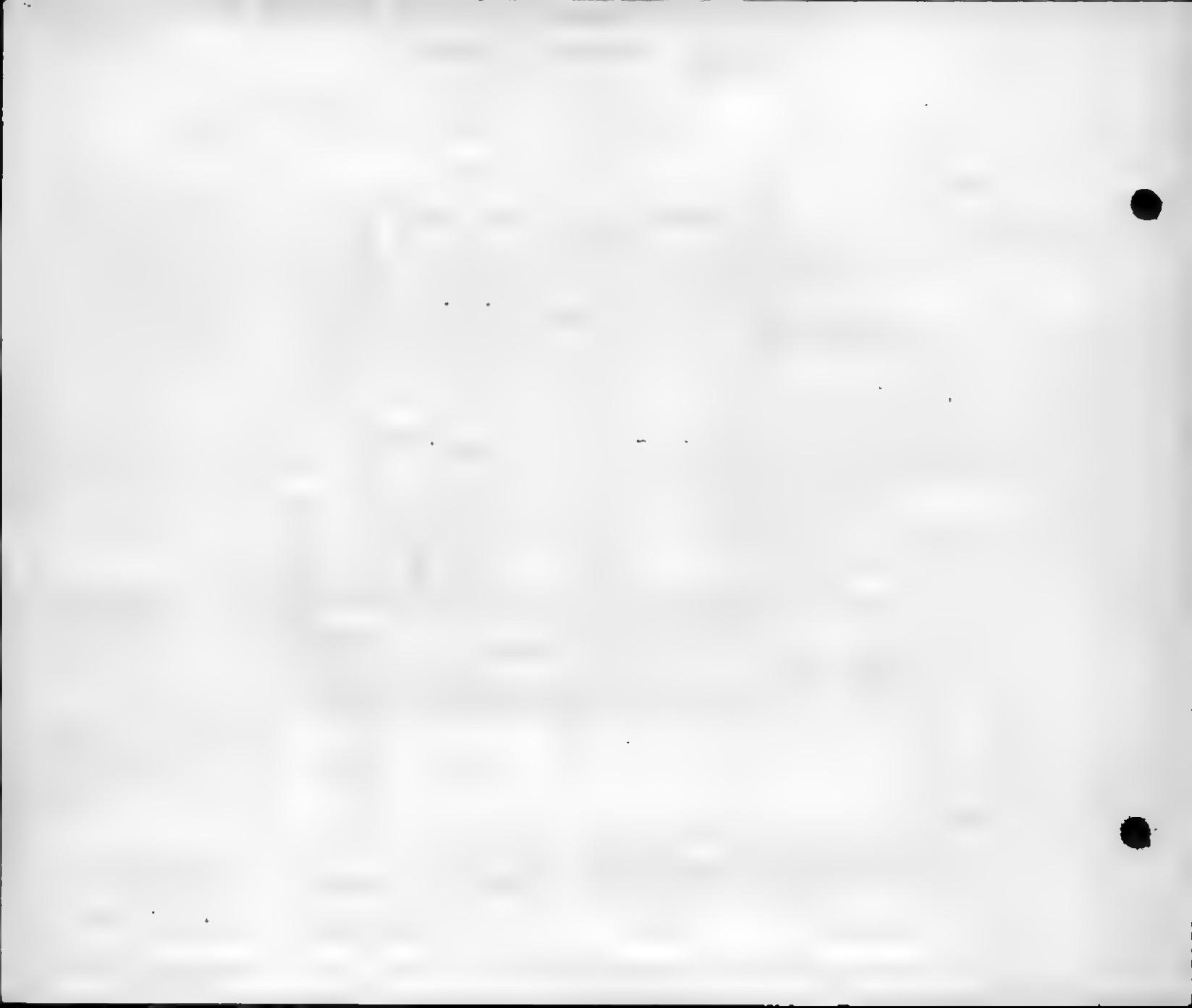
## CERTIFICATE OF DEATH

Reg. Dist. No. 00220

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk (22)</b>		d. STREET ADDRESS <b>23 Kinship Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>23 Kinship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>BENNETT</b>		First <b>MILLER</b>	Middle <b>BARNES</b>	Last <b>BARNES</b>	4. DATE OF DEATH <b>January 17, 1960</b>	Month <b>January</b>	Day <b>17</b>	Year <b>1960</b>	
S. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 27, 1890</b>	9 AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months <b>6</b>	IF UNDER 24 HRS Days <b>23</b>	Hours <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>M. Archie Barnes</b>				14. MOTHER'S MAIDEN NAME <b>Sally Gibson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-09-3475</b>		17. INFORMANT <b>Mattie M. Barnes</b>		Address <b>same as #2</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>481X</b>		<i>Mega Cerebro</i>				INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Influenza</b>		DUE TO <b>3-59</b>							
DUE TO <b>(c)</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-1, 1956</b> to <b>1-17, 1960</b> , that I last saw the deceased alive on <b>1-19, 1950</b> , and that death occurred at <b>10 AM</b> M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state) <b>3 Kinship Bluff 22</b>	DATE SIGNED <b>1-19-60</b>
ACTUAL SIGNATURE <b>Jack C. Collins</b>		M.D.							
PHYSICIAN'S NAME (Type) <b>JACK C. Collins</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/20/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore Co., Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooks Bradbury Jr.</b>		ADDRESS <b>Dundalk 22</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <b>J. L. J. Kinder</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0253

## CERTIFICATE OF DEATH

Reg. Dist. No.

00221

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Cecil</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1 yr - 6 mos.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Charlestown</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>The House in The Pines Nursing Home.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Sarah</b>	Middle <b>Percy</b>	Last <b>Barnes</b>	4. DATE OF DEATH	Month <b>January</b>	Day <b>16</b>	Year <b>19 60</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 21, 1874</b>	9. AGE (In years from birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank</b>		14. MOTHER'S MAIDEN NAME <b>Malcolm Abbie Dudley</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, unknown) <b>NO</b>		16. SOCIAL SECURITY NO		17. INFORMANT <b>Rachel Watts, 3307 W. Rogers Ave. Balto. Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>arteriosclerotic heart disease</b>		DUE TO <b>coronary occlusion</b>		DUE TO <b>arteriosclerotic heart disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
(c)						<b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>In care</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D.</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 7, 1957</b> to <b>Jan. 16, 1960</b> , that I last saw the deceased alive on <b>January 16, 1960</b> , and that death occurred at <b>Charlestown</b> , M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>7818 W. Charlestown Road</b>		DATE SIGNED <b>Manuel Levin, M.D.</b>	
ACTUAL SIGNATURE <b>Manuel Levin</b>		PHYSICIAN'S NAME (Type) <b>MANUEL LEVIN, M.D.</b>					
22a. BURIAL, CREMATION, BURIAL <input type="checkbox"/>		22b. DATE THEREOF <b>1-19-1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Charlestown</b>		22d. LOCATION (City, town, or county) <b>Charlestown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lee A. Patterson &amp; Son</b>		ADDRESS <b>Perryville, Md.</b>		24a. REC'D BY REGISTRAR DATE JAN 20 '60		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



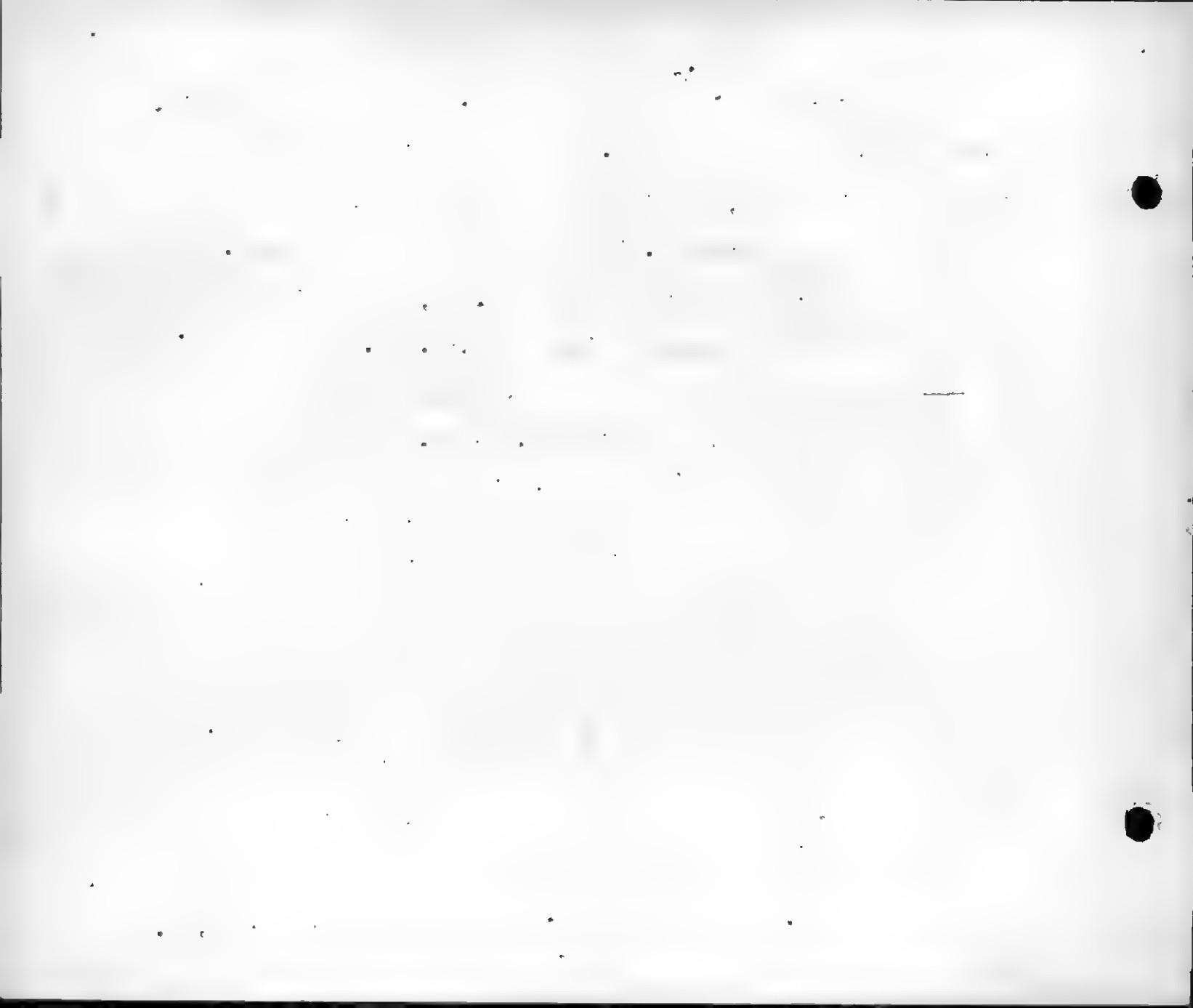
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00222

## 0254 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>10 mos.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home, 98 Smithwood Ave</b>		e. STREET ADDRESS <b>5423 Channing Road</b>	
3. NAME OF DECEASED (Type or print) <b>Rosamond M. Bauer</b>		4. DATE OF DEATH <b>Jan. 6/60</b>	Month Day Year Jan. 6/60 19
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 20, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Western Union</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Balto. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hyland</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214 20 1692</b>	INFORMANT (Son) Mr. John E. Bauer
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) (c) DUE TO  DUE TO  DUE TO		INTERVAL BETWEEN ONSET AND DEATH  <b>Cerebral Vascular Accident.</b> <b>Degenerative Heart Disease.</b> <b>Generalized Arteriosclerosis</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Mar 1959</b> to <b>Jan 6 1960</b>	
21. I certify that I attended the deceased from alive on <b>1/6/60</b> , 19, and that death occurred at <b>1115 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>W.E. Mc Grath</b> M.D. <b>1303 Frederick Rd</b> <b>Catonsville 28nd</b> DATE SIGNED <b>1/8/60</b>	
ACTUAL SIGNATURE <b>W.E. Mc Grath</b>		PHYSICIAN'S NAME (Type) <b>Loudon Pk.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 9/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Pk.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore 20 MD</b>	
22e. FUNERAL DIRECTOR'S SIGNATURE <b>W.E. Funeral Directors, 410 Edmonson</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 13 '60</b>	
ADDRESS <b>Arthur S. Khan</b>		24b. REGISTRAR'S SIGNATURE	



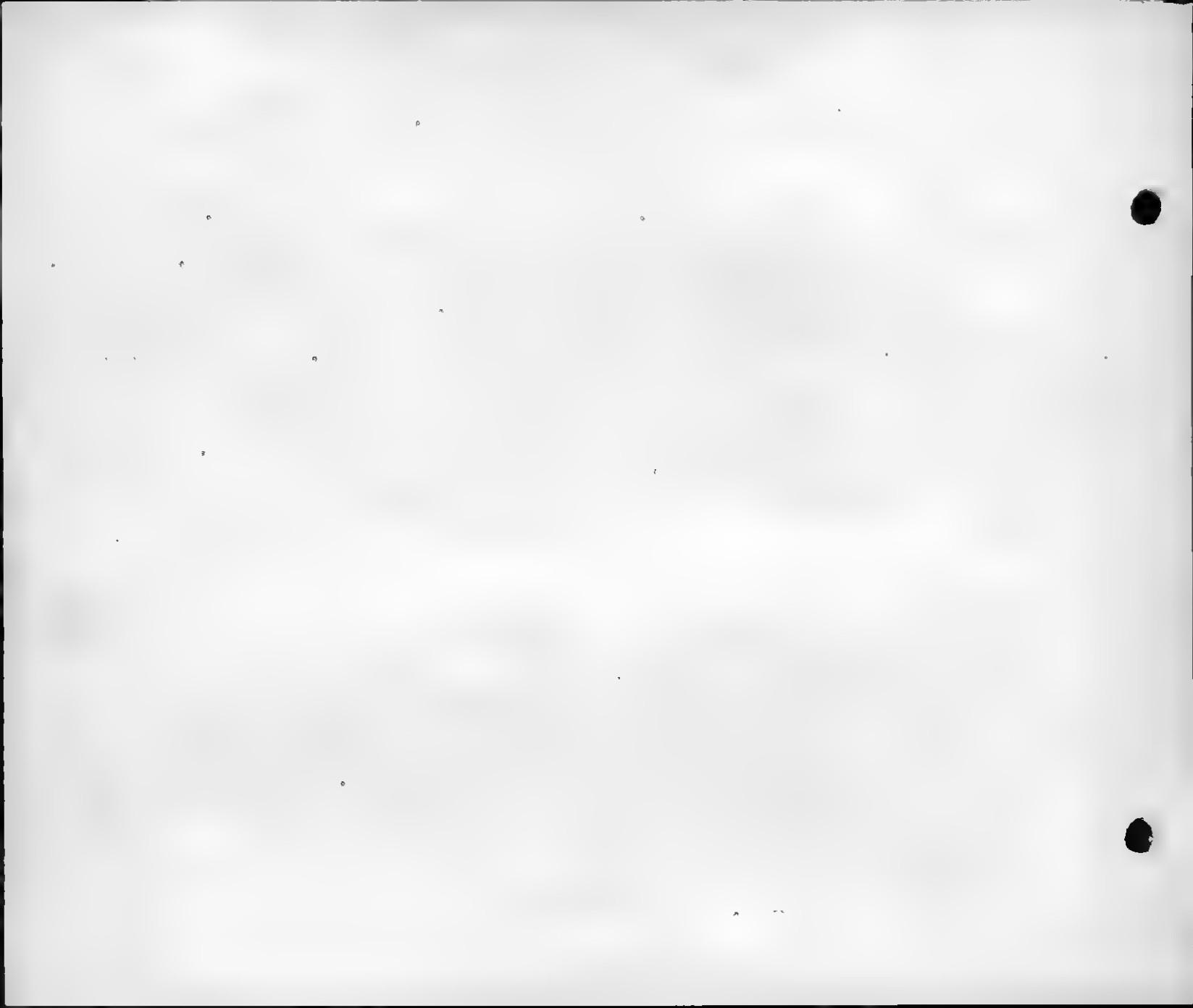
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0213 CERTIFICATE OF DEATH

Reg. Dist. No.

06223

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		b. COUNTY <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>52</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7434 Holabird Ave.</b>		d. STREET ADDRESS <b>7434 Holabird Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>ANNA</b>	Middle <b>E.</b>	Last <b>BEARD</b>		
4. DATE OF DEATH	Month <b>January</b>	Day <b>31</b>	Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 24, 1886</b>		
9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>House Work,</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John R. Byard</b>	14. MOTHER'S MAIDEN NAME <b>Cassie Sable.</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>---</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Dorothy C. Beard</b>	Address <b>Same.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>480X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) <b>VIRUS PNEUMONIA</b> <b>INFLUENZA -</b>					
INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Q-A-5-e-v Disease &amp; Parkinson's Disease</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>Jan 31 1960</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>6800 Maryland Rd</b>	20f. (City or town) <b>Dundalk</b>	(County) <b>Eastern</b>	(State) <b>MD.</b>
21. I certify that I attended the deceased from <b>Jan 27</b> , 1960, to <b>Jan 31, 1960</b> , that I last saw the deceased alive on <b>Jan 30</b> , 1960, and that death occurred on <b>Jan 31, 1960</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>M. B. Davis</b>				ADDRESS (Street, city or town, state) <b>6800 Maryland Rd</b>	DATE SIGNED <b>Jan 22, 1960</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-60.</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Oak Lawn Cemetery</b>	22d. LOCATION (City, town, or county) <b>225 Eastern Bl VD, MD.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Saylor, 901 S. Conkling St. BALTO., MD.</b>			ADDRESS <b>901 S. Conkling St. BALTO., MD.</b>	24a. REC'D BY REGISTRAR <b>Feb 3 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

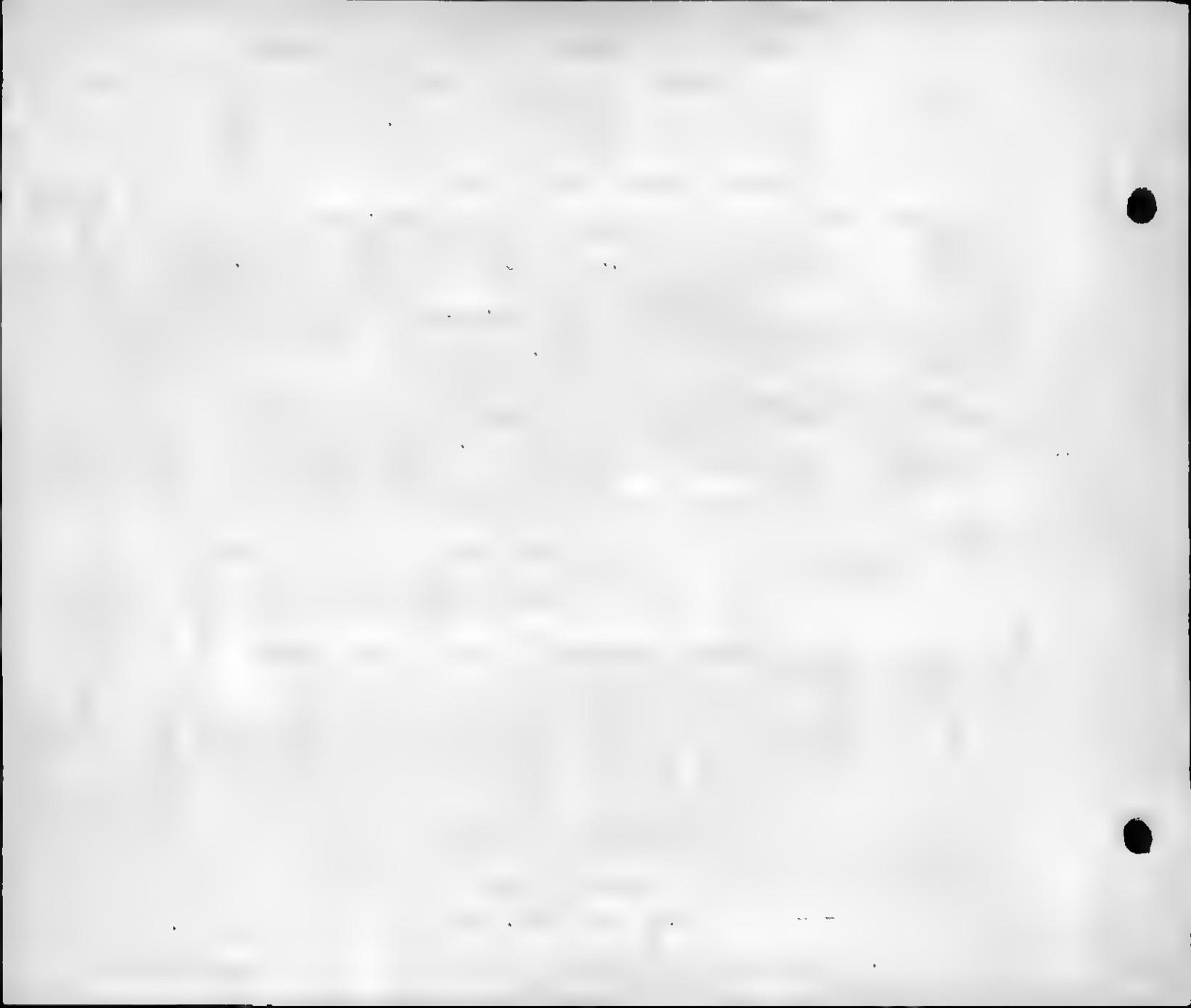
Reg. Dist. No.

CG224

1. PLACE OF DEATH a. COUNTY		0255	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE	
Baltimore		MARYLAND	Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb	b. COUNTY	
Middle River			Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Box 338 Rt 15		Middle River		
d. STREET ADDRESS		Box 338 Rt 15		
3. NAME OF DECEASED (Type or print)		First	Middle	Last
James		W.	Beardsley	Jan.
S. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
male		white		Dec. 7, 1914
9. AGE (in years last birthday)		9. IF UNDER 1 YEAR Months Days		10. IF UNDER 24 HRS. Hours Min.
45 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
Assembly mechanic		The Martin Co.		Maryland
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?
Archibald Beardsley		Ida Crook		USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT
(If yes, give war or dates of service)		213-03-5054		Joan A. Beardsley Address same
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 173.1 DUE TO Carbon Monoxide Poisoning INTERVAL BETWEEN ONSET AND DEATH				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)				
DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fall from front of Lava Pipemaster's Executive Runnner				
20c. TIME OF INJURY Month, Day, Year 1:30 a.m. 1/2 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) Middle River (County) Baltimore (State) Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>M.B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) M.B. DAVIS M.D.		DATE SIGNED 1-4-60		
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1-6-60	22c. NAME OF CEMETERY OR CREMATORIAL Moreland Mem. Park	22d. LOCATION (City, town, or county) Baltimore, Md. (State)
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck 5305 Harford Rd		ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

**TO DENTIST**: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR**: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0239 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00225

**Reg. Dist. No.**

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	c. LENGTH OF STAY IN 1b 10 min.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Reisterstown			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 68 Main St.			f. STREET ADDRESS Old Hanover Road		
3. NAME OF DECEASED (Type or print) Frank Albert Becaft	First	Middle	Last	4. DATE OF DEATH January	Month Day Year
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1922	9. AGE (In years lost by illness) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Truck Laborer		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME Albert Becaft			14. MOTHER'S MAIDEN NAME Bertha Becaft		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-18-2422		17. INFORMANT Mrs Elsie Becaft Reisterstown Md Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 10 min.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)					
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
none			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, Farm, factory, street, office bldg., etc.) none	
20f. (City or town) none		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE	<u>B. D. Caples</u>			DATE SIGNED	
EXAMINER'S NAME (Type)	D. D. Caples, M. D.			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan 23 1960	22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI Old Oakland Cemetery		22d. LOCATION (City, town, or county) Oakland (State) Md
23. FUNERAL DIRECTOR'S SIGNATURE Oliver L. Berryman		ADDRESS Reisterstown Md		24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE Charles S. Krause



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0258 CERTIFICATE OF DEATH

Reg. Dist. No. 00226

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2315 Ellen Rd</b>		e. STREET ADDRESS <b>2315 Ellen Rd</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <b>Edward</b>	Middle <b>Lewis</b>	Last <b>Bendermeyer</b>	4. DATE OF DEATH Month <b>Jan.</b>	Day <b>21</b>	Year <b>1960</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-19-03</b>	9. AGE (In years last birthday) <b>56</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. Hours <b>0</b>	13. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Checker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>brewery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>Edward L. Bendermeyer</b>		14. MOTHER'S MAIDEN NAME <b>Daisy Duvall</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213018851</b>		17. INFORMANT <b>V. Louise Bendermeyer</b>		Address <b>same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>						INTERVAL BETWEEN ONSET AND DEATH		
DUE TO <b>Myocardial degeneration</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema</b>								
DUE TO <b>Cardiac asthma</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9005 Harford Rd.</b>		20f. (City or town) <b>Baltimore, Md.</b>		(County) (State)
21. I certify that I attended the deceased from <b>Jan. 21, 1960</b> , and that death occurred at <b>1745</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>Frank T. Kasik</b>		M.D.		ADDRESS (Street, city or town, state) <b>9005 Harford Rd.</b>		DATE SIGNED <b>1/22/60</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		22b. DATE THEREOF <b>1-25-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Grove</b>		22d. LOCATION (City, town, or county) <b>Harford County, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd</b>		ADDRESS		24a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be relied upon by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00227

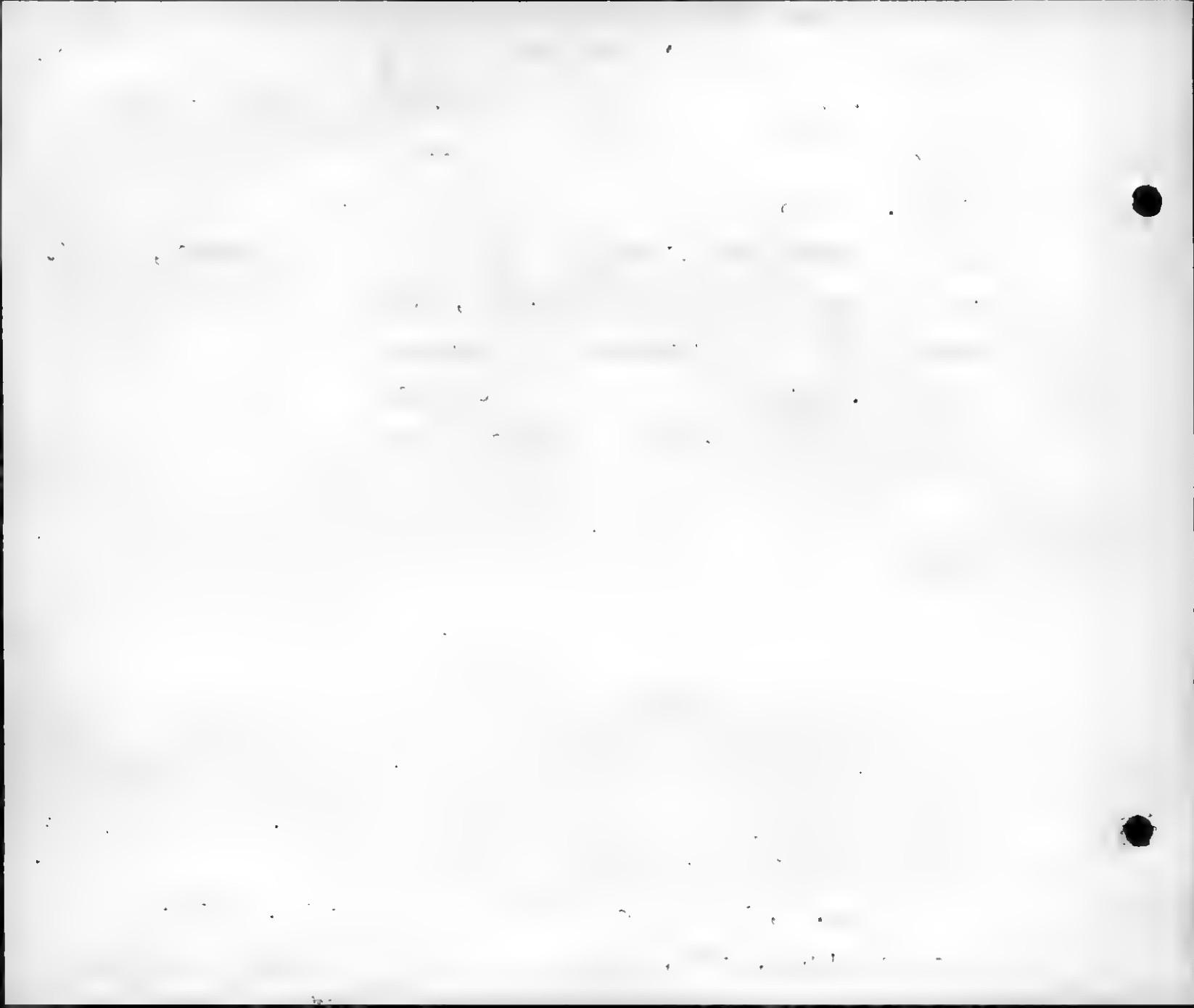
## 0257 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town <b>X Stevenson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1909 E. Joppa Road</b>		e. STREET ADDRESS <b>Stevenson Road</b>	
3. NAME OF DECEASED (Type or print) <b>MYRTLE VIOLA BIDDISON</b>		First <b>MYRTLE</b>	Middle <b>VIOLA</b>
		Last <b>BIDDISON</b>	4. DATE OF DEATH <b>January 19,</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1902</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Millard F. Stiffler</b>		14. MOTHER'S MAIDEN NAME <b>Cora Bosley</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	INFORMANT <b>Family Records</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  <b>151X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  <b>b</b> ) DUE TO  <b>c</b> ) DUE TO		<b>Carcinomatosis</b> <b>Carcinoma (Gastric)</b> <b>3 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  <b>none</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 10, 1960</b> , to <b>Jan 19, 1960</b> , that I last saw the deceased alive on <b>Jan 18, 1960</b> , and that death occurred at <b>7A</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Joseph F. hi Pira</b>		ADDRESS (Street, city or town, state) <b>8400 Loch Raven Blvd</b> DATE/SIGNED <b>1/21/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 22, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood Cemetery</b>
22d. LOCATION (City, town, or county) <b>Parkville, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE  <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0258 CERTIFICATE OF DEATH

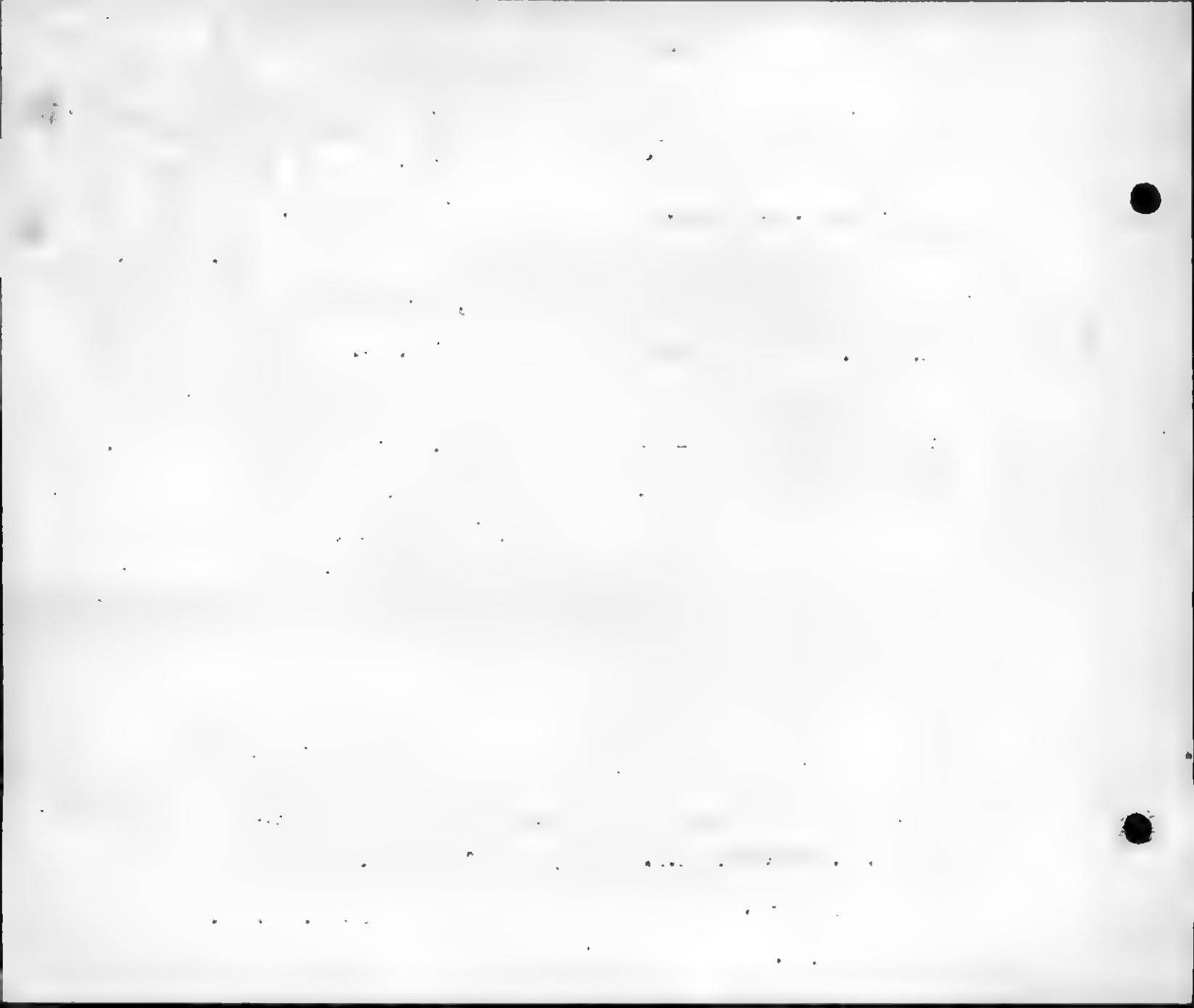
Reg. Dist. No.

06228

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Middle River</b>		c. LENGTH OF STAY IN 1b <b>Gardens Of Faith</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glenn L. Martin Co.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	
3. NAME OF DECEASED (Type or print) <b>John I. Blackwell</b>		4. DATE OF DEATH Month <b>Jan.</b>	Day, Year <b>26, 1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED WIDOWED <input checked="" type="checkbox"/>	NEVER MARRIED DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>June 27, 1906</b>		9. AGE (In years last birthday) <b>53</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Main. Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Aircraft</b>	11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown Blackwell</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown Fersterman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>213-03-7775</b>		INFORMANT <b>Catherine A. Blackwell 8110 Bon Air Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>Hypertensive arteriosclerosis</b> (c) <b>Cardiovascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 1959, to <b>1/26</b> , 1960 that I last saw the deceased alive on <b>1/25</b> , 1960, and that death occurred at <b>8:45 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>W. H. Townsend</b> ADDRESS (Street, city or town, state) <b>14 E Enza St Baltimore 2, Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Gardens Of Faith</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Transit Funeral Home</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 29 '60</b>	
ADDRESS <b>7401 Belair Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Trahan</b>	

TO HOSPITAL may be referred to the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours of death.

VS A15 (4)  
1SM 9/58



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0259 CERTIFICATE OF DEATH

Reg. Dist. No. **00229**

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	c LENGTH OF STAY IN 1b <i>House on Lines</i>	d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	e. COUNTY <i>101-1</i>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>MEYER</i>		d. STREET ADDRESS <i>2906 W. Strathmore Ave</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>MEYER</i>	Middle <i>BLANKMAN</i>	Last <i>1 - 20 - 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>67 yrs</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Restaurant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>self</i>	11. BIRTHPLACE (State or foreign country) <i>Russia</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Max</i>	14. MOTHER'S MAIDEN NAME <i>Anna</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>rose blankman - bane</i>	INFORMANT <i>Cecilia Vacalessa Lee</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>1 mo</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 1959</i> , to <i>1/20 1960</i> that I last saw the deceased alive on <i>1/20 1960</i> , and that death occurred at <i>9A M</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edward F. Kalline</i>		ADDRESS (Street, city or town, state) <i>4300 Liberty, Hts, MD</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <i>1/20/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-22-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Shoreline Crematorium</i>	22d. LOCATION (City, town or county) <i>Baltimore Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Jr</i>	ADDRESS <i>2100 Eutaw Place</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 21 1960</i>	24b. REGISTRAR'S SIGNATURE <i>S. Knob</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0260 CERTIFICATE OF DEATH

Reg. Dist. No. 00230

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Foxleigh Nursing Home</i>		e. STREET ADDRESS <i>3407 Old Post Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Bessie</i>	Middle <i>Bloom</i>	4. DATE OF DEATH <i>1/18/60</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Cowland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Howard Hamburger</i>	14. MOTHER'S MAIDEN NAME <i>Hannah Leff</i>	Address <i>Mrs. Flannie B. Bernstein</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>111-11-1111</i>	INFORMANT <i>Mrs. Flannie B. Bernstein</i>	17. INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>502.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <i>Bronch Pneumonia</i> (c) DUE TO <i>Chronic Bronchitis</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) <i>Fracture of hip Senile Psychosis.</i>		20. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>1954</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5320 Park Heights Ave</i>	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>January 18, 1960</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. (City or town) <i>Baltimore</i> (County) <i>Maryland</i> (State)
21. I certify that I attended the deceased from <i>1954</i> , 19, to <i>1-18</i> , 1960, that I last saw the deceased alive on <i>1-18</i> , 1960, and that death occurred at <i>8:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Theodore Cooper</i> M.D. PHYSICIAN'S NAME (Type) <i>Theodore Cooper MD</i> ADDRESS (Street, city or town, state) <i>Baltimore-15 Md.</i> DATE SIGNED	22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/20/60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oaks Israel Cemetery Washington D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sol Bernstein - Bio Inc. Restoration</i>	24. ADDRESS <i>Baltimore, Md.</i>	25. REC'D. BY REGISTRAR <i>JAN 22 1960</i>	26. REGISTRAR'S SIGNATURE <i>William S. Young</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0229

## CERTIFICATE OF DEATH

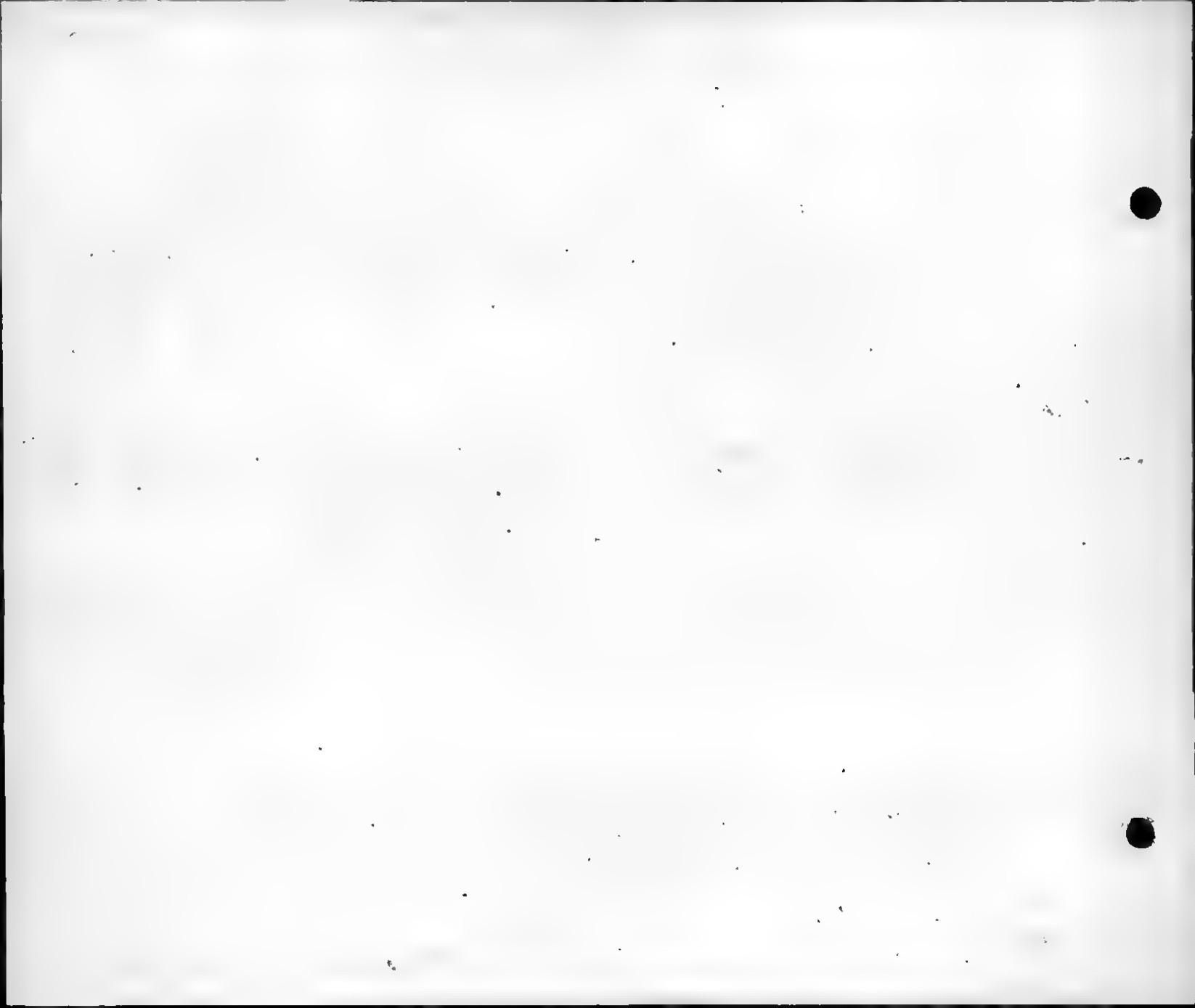
Reg. Dist. No.

00231

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>		c. LENGTH OF STAY IN 1b <b>10YRS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1609 WOODSIDE AVENUE</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HALETHORPE</b>	
3. NAME OF DECEASED (Type or print) <b>ANNA</b>		First <b>E.</b>	Middle <b>BOOZ</b>
4. DATE OF DEATH <b>JANUARY 28, 1960</b>		Month Day Year	Month Day Year
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 11, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	11. BIRTHPLACE (State or foreign country) <b>WASH. COUNTY MARYLAND</b>
13. FATHER'S NAME <b>WESLEY SHANKS</b>		14. MOTHER'S MAIDEN NAME <b>ANNA SHADRACH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	INFORMANT Address <b>MISS LILLIAN BOOZ 1609 WOODSIDE AVENUE</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. DUE TO (b) <i>Coronary Occlusion</i> DUE TO (c) <i>Arterio-sclerotic Heart Disease</i>			
INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 1957</b> , to <b>1/28 1960</b> , that I last saw the deceased alive on <b>1/28 1960</b> , and that death occurred at <b>77 M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. N. Frederick</i>		ADDRESS (Street, city or town, state) <b>1305 Francis Ave</b>	
PHYSICIAN'S NAME (Type) <b>J. N. Frederick MD</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/1/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>LOUDON PARK CEMETERY</b>
22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY S. SINGER &amp; SONS INC BALTIMORE MARYLAND</b>		24a. REC'D BY REGISTRAR <b>FEB 2 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Singer</i>

TO HOSPITAL,  PHYSICIAN,  ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

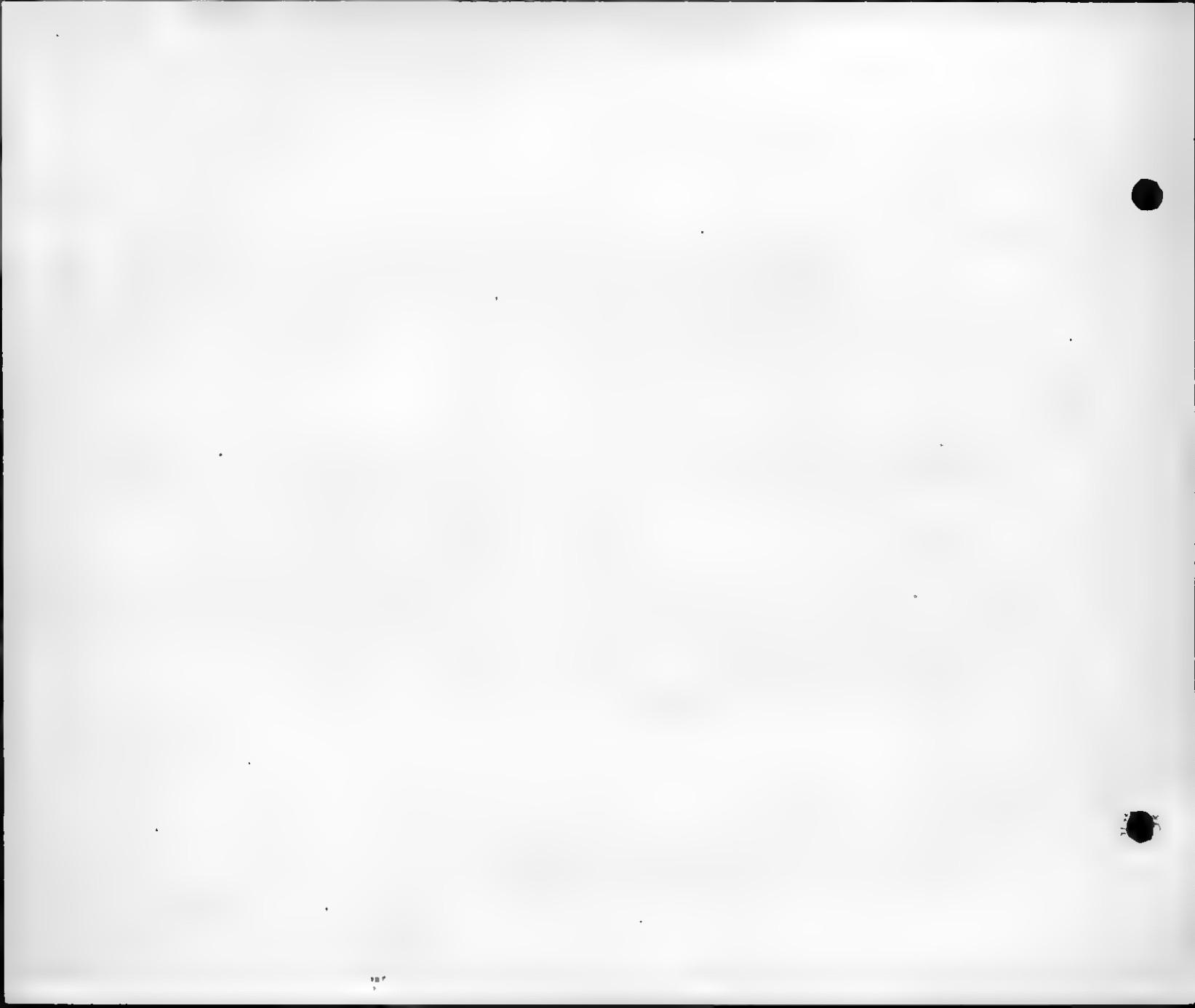
## 0261 CERTIFICATE OF DEATH

Reg. Dist. No.

00232

**TO HOSPITAL** [REDACTED] may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE					
Baltimore		MARYLAND Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb RURAL - Middle River 3 years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 605 Wampler Road		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - Middle River					
3. NAME OF DECEASED (Type or print)		First	Middle				
HENRY		L	THRU				
4. DATE OF DEATH		Last	Month Day Year				
Jan. 26			1960				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years at birthday) 58 yrs	10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
Male		White		July 27, 1901	58 yrs		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
CRANE OPERATOR		Copper REVERE		Baltimore, Maryland		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
George Botzler		FRANCES E.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
No		216-01-9008 Anna Judo Eliza Botzler		605 Wampler Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Admission to hospital 10 minutes					
163X		DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)					
{		{					
DUE TO							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		none					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 14, 1959, to Jan 25, 1960, that I last saw the deceased alive on January 25, 1960, and that death occurred at 8 P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE		Irving R. Beck					
PHYSICIAN'S NAME (Type)		M.D. House Call 400 Belair Rd. 1-266					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
Burial		1-30-60		Bel Air Memorial Gardens		Bel Air Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
Philip E. Clark 1211 Chesapeake Ave.				DATE FEB 2 '60		Catherine & Thomas	



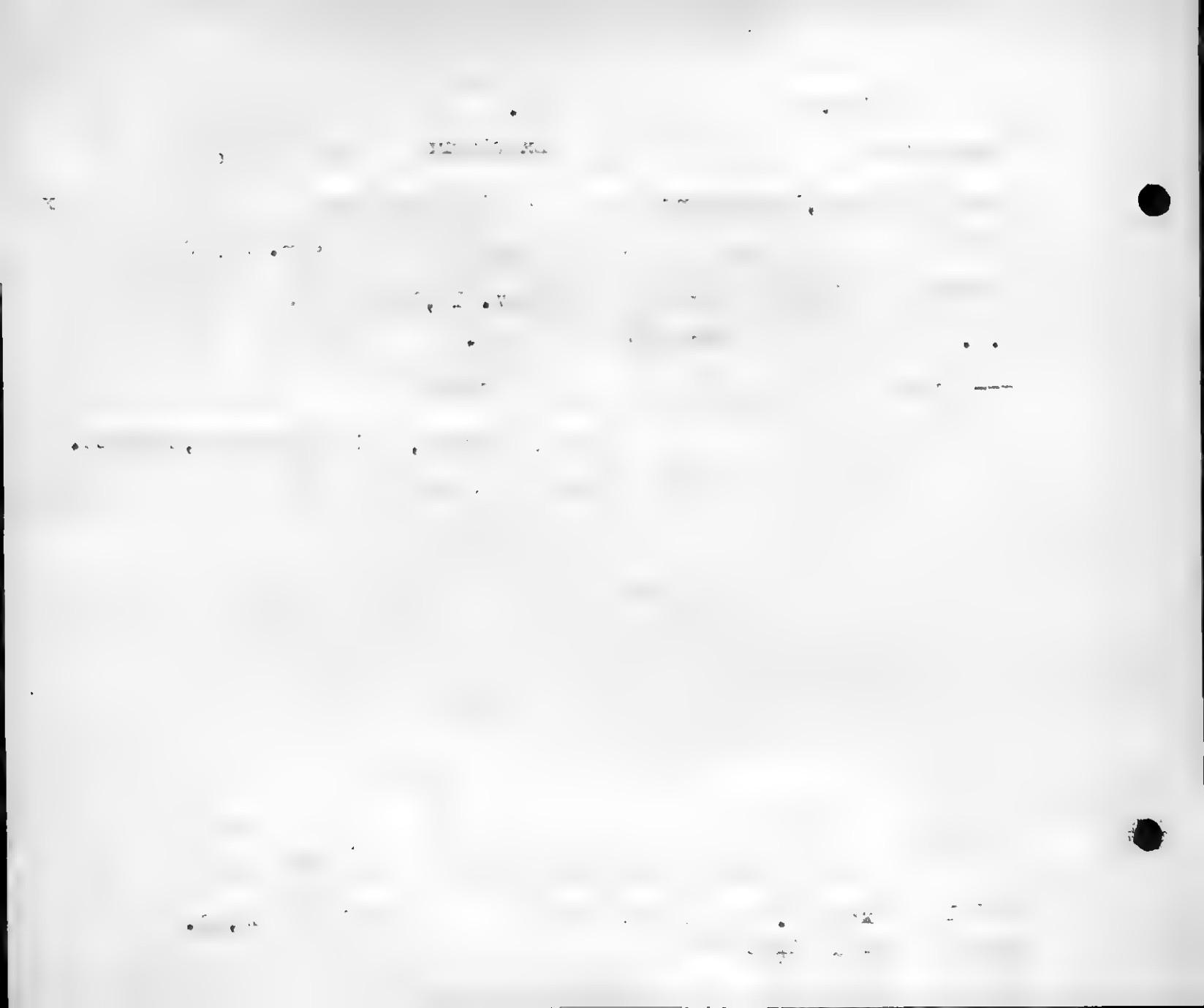
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**0262 CERTIFICATE OF DEATH**

00233

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN Tb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> <b>Catonsville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, 16 Fusting Ave</b>		e. STREET ADDRESS <b>4 Hill Top Road</b>	
3. NAME OF DECEASED (Type or print) <b>Alice</b>		First <b>G</b>	Middle <b>Brach</b>
4. DATE OF DEATH <b>Jan. 28/60</b>		Month <b>Jan.</b>	Day <b>28</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Nov. 18, 1876</b>		9. AGE (In years last birthday) <b>83</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>White</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO 17. INFORMANT <b>Philip Brach, 4 Hill Top Road, zone 28.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  4. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.  (b) DUE TO (c)		<b>Bronchopneumonia</b>  <b>Pulmonary Edema</b>  <b>Arteriosclerotic Cardiovascular Disease</b> <b>malnutrition</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Nov 1941, to Jan 1960</b>	
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred at _____ from the causes and on the date stated above.		22b. DATE SIGNED <b>29 Jan 60</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. H. Baylus</b>		22d. ADDRESS <b>1600 Wilkins Ave</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 1/60</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore 29 Ma.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Traeger</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>	
24b. ADDRESS <b>4101 Lamondsch Rd</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Traeger</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0263

## CERTIFICATE OF DEATH

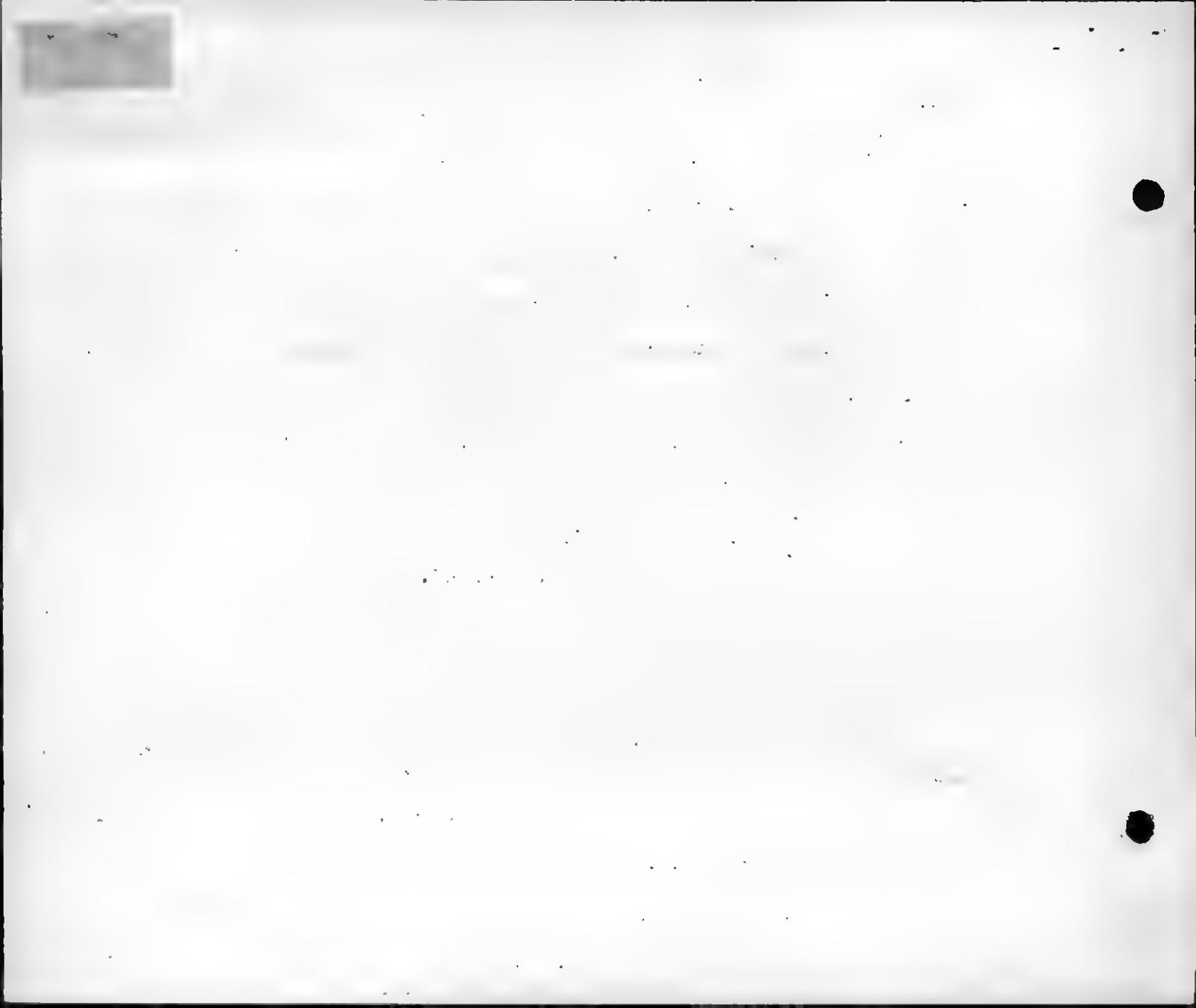
Reg. Dist. No.

001234\*

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>53 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mount Airy</b>		d. STREET ADDRESS <b>Rt. 3, St. Michaels Rd. Poplar Sprgs</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) <b>HERBERT</b>		First <b>C.</b>	Middle <b>BRADY</b>	Last <b>BRADY</b>	4. DATE OF DEATH <b>January 22 1960</b>	Month <b>January</b>	Day <b>22</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1888</b>		9. AGE (in years last birthday) <b>71 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter- Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Buildings</b>		11. BIRTHPLACE (State or foreign country) <b>Silverhill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Cornelius O. Brady</b>		14. MOTHER'S MAIDEN NAME <b>Mary Day</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md., FORT HOWARD DIVISION</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE PYELONEPHRITIS, BILATERAL</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>4 WEEKS</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) <b>XOGENX</b>								
UNKNOWN								
(c) <b>DIABETES MELLITUS</b>								
UNKNOWN								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
19. WAS AUTOPSY PERFORMED? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 P. M.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
VA								
21. I certify that I attended the deceased from November 30, 1959, to January 22, 1960, <b>5:45 A.M.</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/22/60</b>								
DATE SIGNED								
ACTUAL SIGNATURE <i>W. J. PIJANOWSKI</i>								
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>1-26-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington National Cemetery</b>		22d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto. 14, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Curious S. Krause</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

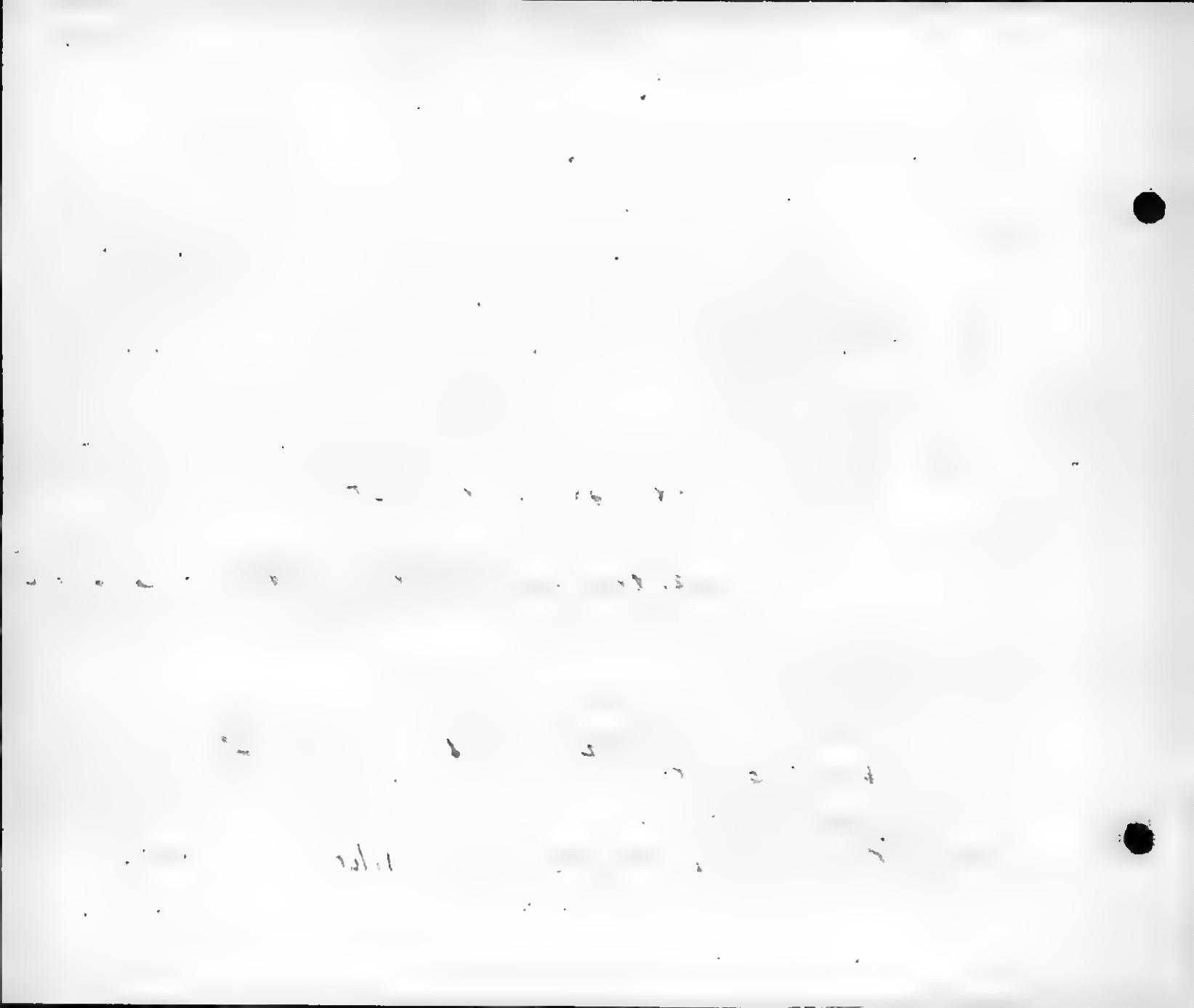
## 0214 CERTIFICATE OF DEATH

00235

Reg. Dist. No.

**TO HOSPITAL** by the hospital or attending physician;  
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 7 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>50 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>7324 HOLABIRD AVENUE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>MICHAEL</b>		First	Middle
		Last <b>BRODOWSKI</b>	
4. DATE OF DEATH	Month <b>JANUARY</b>	Day <b>30, 1960</b>	Year <b>19</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 29, 1889</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <b>70 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MOULDER PIPE MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED 5 YRS.</b>	
11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN BRODOWSKI</b>		14. MOTHER'S MAIDEN NAME <b>HELEN WINGO</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216 05 81 95</b>	
		INFORMANT <b>MRS PAULINE BRODOWSKI</b>	Address <b>7324 HOLABIRD AVE,</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b>			
DUE TO <b>420.1</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)			
DUE TO <b>Generalized Arteriosclerosis</b>			
(c) <b>Feb 1960</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>Feb 1960</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Feb 1958</b> to <b>Jan 1960</b> that I last saw the deceased alive on <b>Mar 26, 1960</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. 2903 WEST WOODWELL AVENUE</b>	
ACTUAL SIGNATURE <b>Oswald Berrios</b>		DATE SIGNED <b>21/1/60</b>	
PHYSICIAN'S NAME (Type) <b>Oswald Berrios MD</b>			
22a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		22b. DATE THEREOF <b>2/3/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>CHRIST CHURCH CEMETERY</b>
		22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC BALTIMORE MARYLAND</b>		ADDRESS <b>DATE</b>	24a. REC'D BY REGISTRAR <b>FEB 3 1960</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

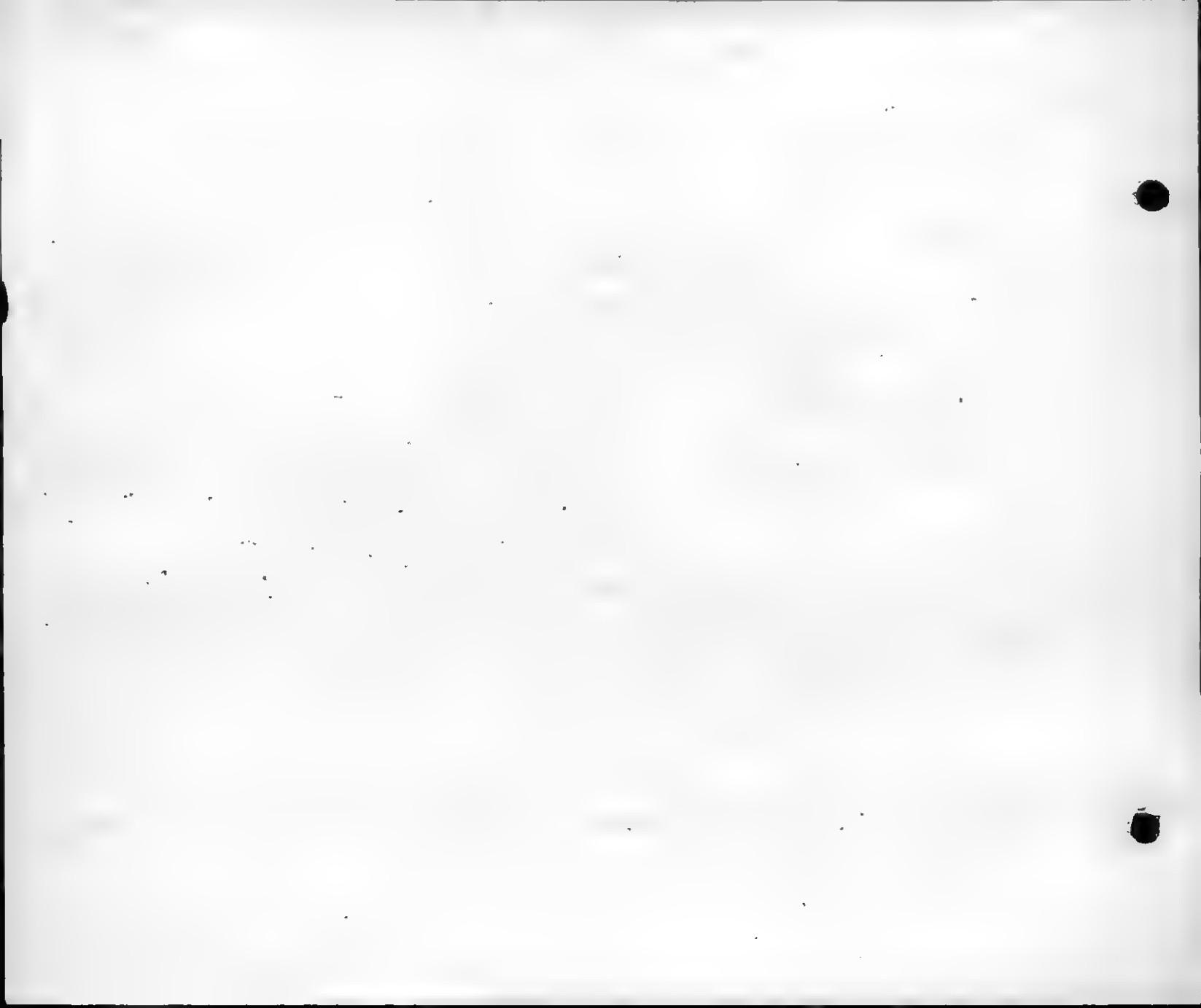
## 0264 CERTIFICATE OF DEATH

00236

Reg. Dist. No.

**TO HOSPITAL** or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution Residence before admission] a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  X BALTIMORE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6002 Lakehurst Drive		d. STREET ADDRESS 16002 Lakehurst Drive #10	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First BERTIE	Middle M.	Last BROOKS
4. DATE OF DEATH	Month January	Day 1	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 27, 1886
9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Christopher Winterling		14. MOTHER'S MAIDEN NAME Margaret -----	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yn, no, or unknown) No	16. SOCIAL SECURITY NO 213-09-2413D	INFORMANT Mrs. Jewel E. Mullineaux	Address 6002 Lakehurst Drive
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  197X DUE TO Respiratory failure 4 days			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Carcinoma of left breast 2 years (c) DUE TO with metastasis to liver; jaundiced 2 weeks Patient was inoperable when first seen so was given deep x-ray treatment.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 3, 1957, to Oct. 3, 1957, that I last saw the deceased alive on Oct. 3, 1957, and that death occurred at 10:00 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE  PHYSICIAN'S NAME (Type)	ADDRESS (Street, city or town, state) Maurice E. Shamer, M.D. 3800 N. Delarue Ave. - Baltimore City		
DATE SIGNED			
22a. BURIAL, CREMATION REMOVAL (Specify) Entombment	22b. DATE THEREOF 1/4/59	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Mausoleum	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickens & Sons	ADDRESS Baltimore, Md.	24a. REC'D BY REGISTRAR DATE JAN 4 1960	24b. REGISTRAR'S SIGNATURE Arthur S. Kline



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0265 CERTIFICATE OF DEATH

Reg. Dist. No. 00237

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catoctinville</i>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>SUMMIT Nursing Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i> 3 Vol - 4	
3. NAME OF DECEASED (Type or print) <i>Amelia</i>		d. STREET ADDRESS <i>2672 Wilkens Ave</i>	
4. DATE OF DEATH <i>JAN. 25 1960</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Sept. 5, 1871</i>
8. AGE (In years lost birthday) 8 yrs.		9. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore Md. U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>John Eichner</i>		14. MOTHER'S MAIDEN NAME <i>SUSAN Laird</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Mr. Edward Walters</i>		Address 1001 De Soto Rd <i>Baltimore Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Pneumonia Bilateral.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i></i>			
(b) DUE TO <i></i>			
(c) <i></i>			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White Nat while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i>58</i>	
(County) <i></i>		(State) <i></i>	
21. I certify that I attended the deceased from <i>June 1958</i> to <i>1/25/60</i> that I last saw the deceased alive on <i>1/15/60</i> , 19 <i>60</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above			
ACTUAL SIGNATURE <i>H. E. McGrath</i>		ADDRESS (Street, city or town, state) <i>1303 Frederick Rd</i>	
NAME (Type) <i>H. E. McGrath</i>		DATE SIGNED <i>1/27/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 28, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>London Park Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. L. Johnson</i>		ADDRESS <i>3512 Frederick Ave. - 29-</i>	
24a. REC'D BY REGISTRAR <i>Jan 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Moore</i>	



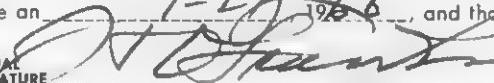
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0268

## CERTIFICATE OF DEATH

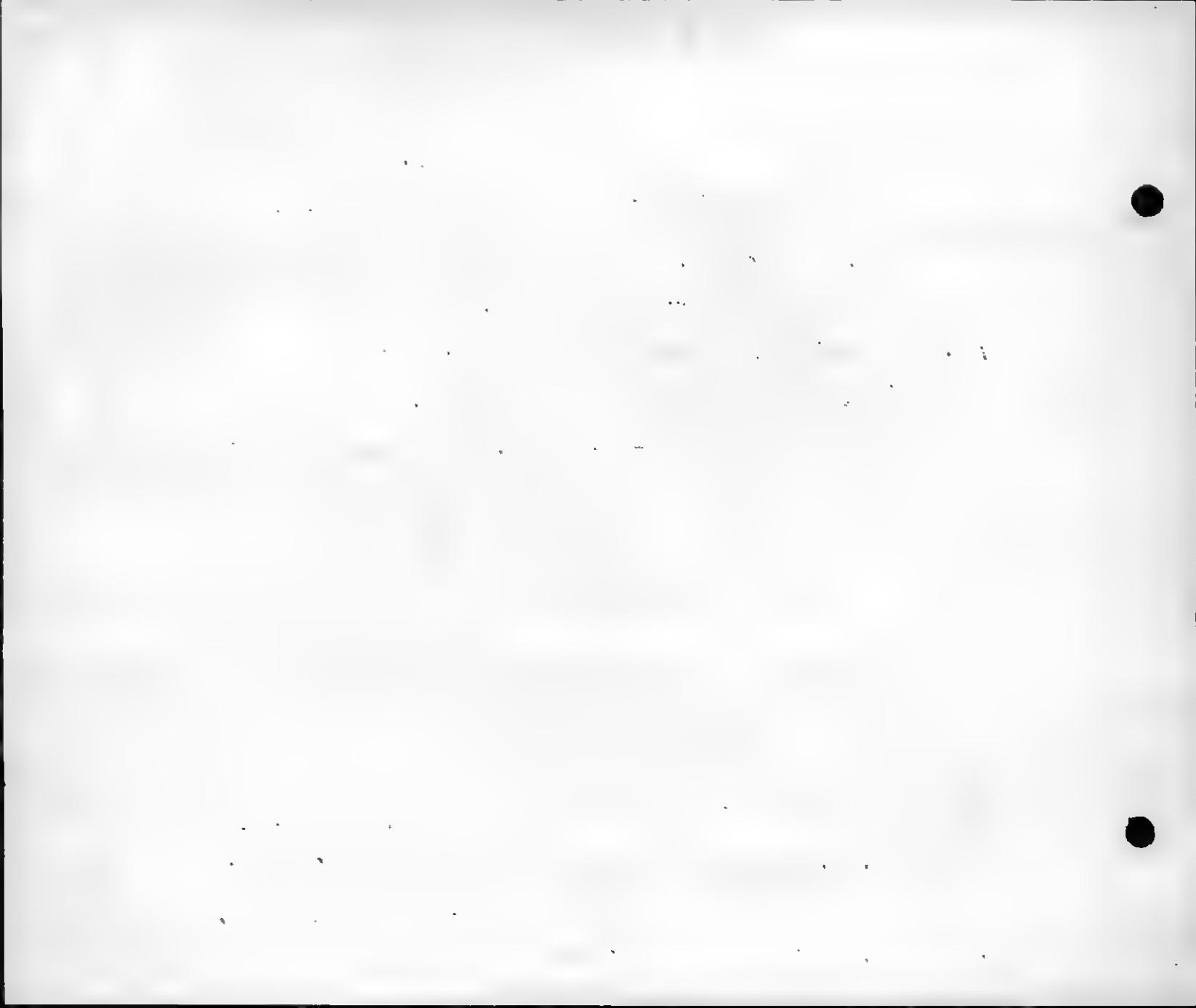
Reg. Dist. No.

00238

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Anneslie</b>		c. LENGTH OF STAY IN 1b RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>515 Windwood Road</b>		e. STREET ADDRESS <b>515 Windwood Road</b>	
3. NAME OF DECEASED (Type or print) <b>Mr. Edward J.</b>		First	Middle
		Last	<b>Cain</b>
4. DATE OF DEATH <b>January 29th 1960</b>		Month	Day
		Year	
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Dec. 30, 1876</b>		9. AGE (In years lost birthday) <b>83</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Marine Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>11 BIRTHPLACE (State or foreign country) Massachusetts</b>	
13. FATHER'S NAME <b>John Edward Cain</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Marr</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>217-16-7061</b>	
17. INFORMANT <b>Mrs. Carl Seward</b>		Address <b>515 Windwood Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral vascular accident</b>		INTERVAL BETWEEN ONSET AND DEATH	
3812 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO		<b>Arterial sclerosis</b>	
(c) DUE TO		<b>old age</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-20 1959</b> to <b>1-29 1960</b> , and that death occurred at <b>5:2 AM</b> , from the causes and on the date stated above. alive on <b>1-27 1960</b> , and that death occurred at <b>5:2 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1123 St. Paul Street</b>		DATE SIGNED	
ACTUAL SIGNATURE 			
PHYSICIAN'S NAME (Type) <b>H. D. Franklin</b>		Baltimore, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/1/1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Road #14</b>		ADDRESS <b>Leonard J. Ruck 5305 Harford Road #14</b>	24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



00253

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN lb		d. STATE MARYLAND b. COUNTY BALTIMORE					
DUNDALK						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3461 LOCUTH ROAD		53 DUNDALK		f. STREET ADDRESS					
3. NAME OF DECEASED (Type or print)		First VIVIAN	Middle IRENE	Last CAMPBELL	4. DATE OF DEATH	Jan	Day 20	Year 1960			
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	IF UNDER 1YEAR	IF UNDER 24 HRS.				
FEMALE		WHITE		JAN 28, 1910	45 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country)			12 CITIZEN OF WHAT COUNTRY?		
AT HOME						WEST VIRGINIA			U.S.A		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address					
LLOYD SILCOTT			NUTTER			CHAS J CAMPBELL 3461 LOCUTH RD					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No		16. SOCIAL SECURITY NO.		17. INFORMANT							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Hypertensive Cardio-vascular DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Disease											
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)  Homicide									
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>  M. B. Davis MD											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)  M. B. Davis MD		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								DATE SIGNED  1/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/22/60		22c. NAME OF CEMETERY OR CREMATORIAL Mt. Carmel		22d. LOCATION (City, town, or county) BALTIMORE MD		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE  ILLINOIS FUNERAL HOME - DUNDALK		ADDRESS		24a. REC'D BY REGISTRAR Date 1/25/60		24b. REGISTRAR'S SIGNATURE Alice E. Knapp					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00240

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 28		c. LENGTH OF STAY IN 1b Catonsville 28	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7 Magruder Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Roland	Middle S.	Last Carbaugh
4. DATE OF DEATH	Month January	Day 21	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1898
9. AGE (in years at birthday) 61 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President	11. KIND OF BUSINESS OR INDUSTRY H & G Armature Generator Service	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Snively Carbaugh	14. MOTHER'S MAIDEN NAME Mary J. Osbon	Address Mrs. L. May Carbaugh, 7 Magruder Ave, Catonsville	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. 216-28-6776	17. INFORMANT Mrs. L. May Carbaugh, 7 Magruder Ave, Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Due to</i> (c) <i>Due to</i>		INTERVAL BETWEEN ONSET AND DEATH <i>From atherosclerosis &amp; gangrene in stump of amputated rt. leg.</i> <i>Cadav. Vascular Disease &amp; Diabetes</i> <i>15 days</i> <i>18 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Amputed rt leg mid thigh 9/2/59</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 3432 Frederick Ave	20f. (City or town) Baltimore	(County) Baltimore
21. I certify that I attended the deceased from <u>4/3</u> , 19 <u>43</u> , to <u>11/31</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>60</u> , and that death occurred at <u>12:50 P.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Eliot W. Johnson</i> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) Eliot W. Johnson DATE SIGNED <u>2/2/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2-3-60	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore (State)
23. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		24a. REC'D BY REGISTRAR FEB 3 '60	24b. REGISTRAR'S SIGNATURE Gather & Tice

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After his certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3 spmth C

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

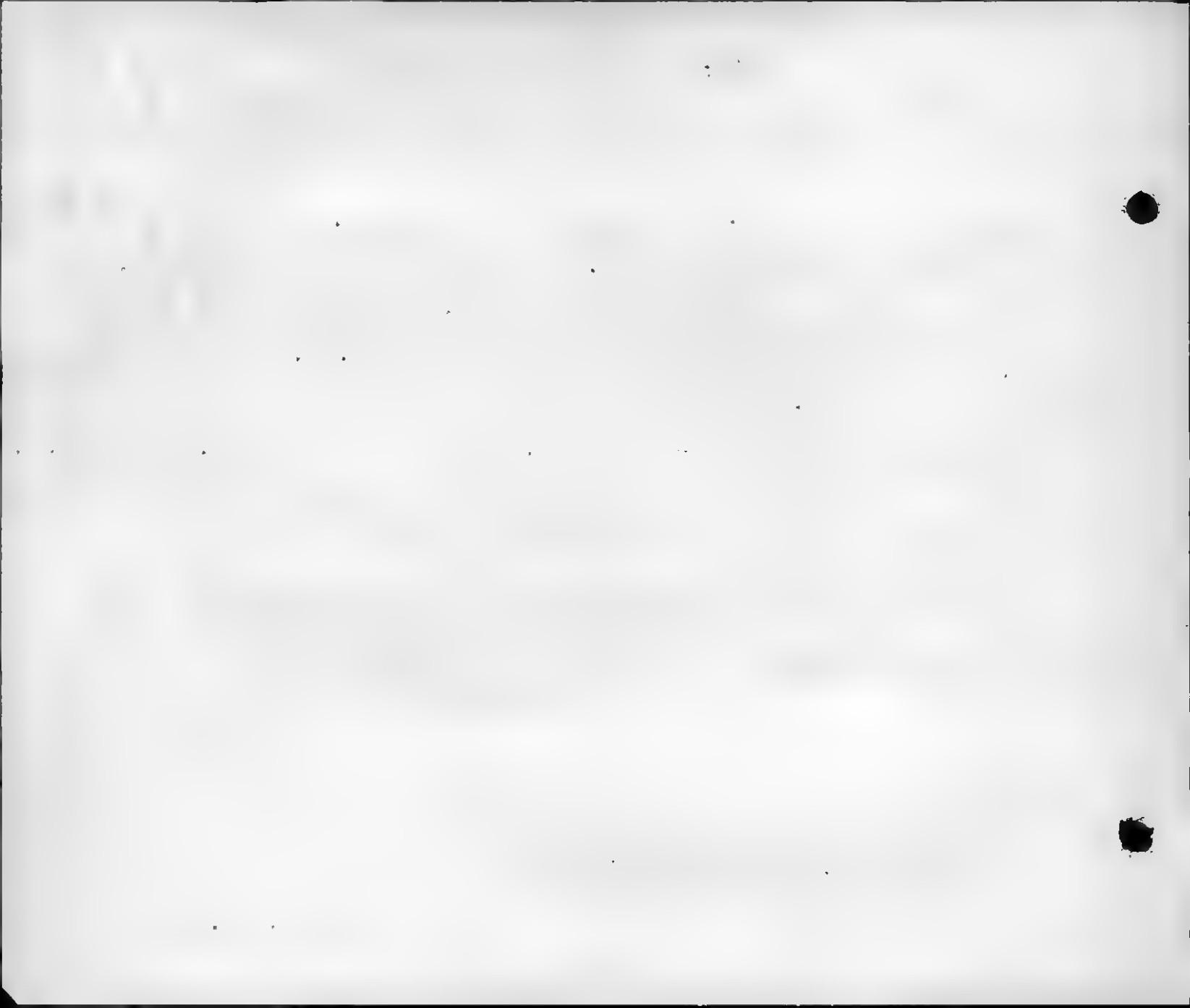
00241

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  White Marsh	c. LENGTH OF STAY IN 1b  Red Lion Rd.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  White Marsh	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Red Lion Rd.	d. STREET ADDRESS  Red Lion Rd.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)  George F. Carr	First Middle Last	4. DATE OF DEATH  January 31, 1960	Month Day Year
5. SEX Male White	6. COLOR OR RACE WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17, 1909
9. AGE (In years last birthday) 50 yrs		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Harford Co. Md.
12. CITIZEN OF WHAT COUNTRY USA		13. FATHER'S NAME James M. Carr	
14. MOTHER'S MAIDEN NAME Louise Frey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. 215-10-6716		17. INFORMANT Mrs. Margaret Carr Red Lion Rd. White Marsh, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.1 DUE TO Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Coronary occlusion		1/2 hour	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 31, 1960, to Jan 31, 1960, that I last saw the deceased alive on Jan 31, 1960, and that death occurred at 7:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE THEODORE E. EVANS		ADDRESS (Street, city or town, state) 9660 Belair Rd. Baltimore, Md. DATE SIGNED Jan 31/60	
PHYSICIAN'S NAME (Type) THEODORE E. EVANS		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 214-1960		22c. NAME OF CEMETERY OR CREMATORIAL Belair Memorial Gardens	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home		22d. LOCATION (City, town, or county) Belair, Md. (State)	
ADDRESS 7401 Belair Rd.		24a. REC'D. BY REGISTRAR FEB 3 '60 DATE	
		24b. REGISTRAR'S SIGNATURE Cirius L. Hause	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)  
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0269 CERTIFICATE OF DEATH

Reg. Dist. No.

00242

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>7</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>3933 Patterson Ave.,</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED First <i>Col. HENRY DeVRIES CASSARD.</i> Middle <i>J.</i> Last <i>Jan.</i>				4. DATE OF DEATH Month <i>5</i> Day <i>1960</i>				
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>4-11-1895</i>	9. AGE (in years, months, birthday) <i>64</i>	IF UNDER 1 YEAR <input type="checkbox"/> Months <i>0</i>	IF UNDER 24 HRS <input type="checkbox"/> Days <i>0</i>	IF UNDER 24 HRS <input type="checkbox"/> Hours <i>0</i>	IF UNDER 24 HRS <input type="checkbox"/> Min <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Army Officer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army</i>				
11. BIRTHPLACE (State or foreign country) <i>Kentucky</i>				12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>Reuben R. Cassard</i>				14. MOTHER'S MAIDEN NAME <i>Cora DeVries</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>				16. SOCIAL SECURITY NO. <i>W.W. I &amp; II</i>				
17. INFORMANT <i>Henry D. Cassard Jr.</i>				Address <i>Bethesda, Md.</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Probable Acute Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>immediate</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Chronic Bronchitis asthma</i>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>July</i> 19 <i>57</i> p.m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>3600 Lochearn Dr.</i>				
20f. (City or town) <i>BALTO. 7, MD</i>				(County) <i>Baltimore Co.</i> (State) <i>MD</i>				
21. I certify that I attended the deceased from <i>January 4, 1960</i> , to <i>January 6, 1960</i> , that I last saw the deceased alive on <i>January 4, 1960</i> , and that death occurred at <i>7A M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>3600 Lochearn Dr., BALTO. 7, MD</i> DATE SIGNED <i>Jan 5, 1960</i>								
ACTUAL SIGNATURE <i>Daniel Baskal</i>		PHYSICIAN'S NAME (Type) <i>DANIEL BASKAL, M.D.</i>						
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-7-60</i>		22c. NAME OF CEMETERY OR CREAMERY <i>Mt. Olivet</i>		22d. LOCATION (City, town, or county) <i>Baltimore, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur A. Height</i>		ADDRESS <i>Oxon Hill, Md.</i>		24a. REC'D. BY REGISTRAR <i>JAN 11 1960</i>		24b. REGISTRAR'S SIGNATURE <i>John E. Moore</i>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0270

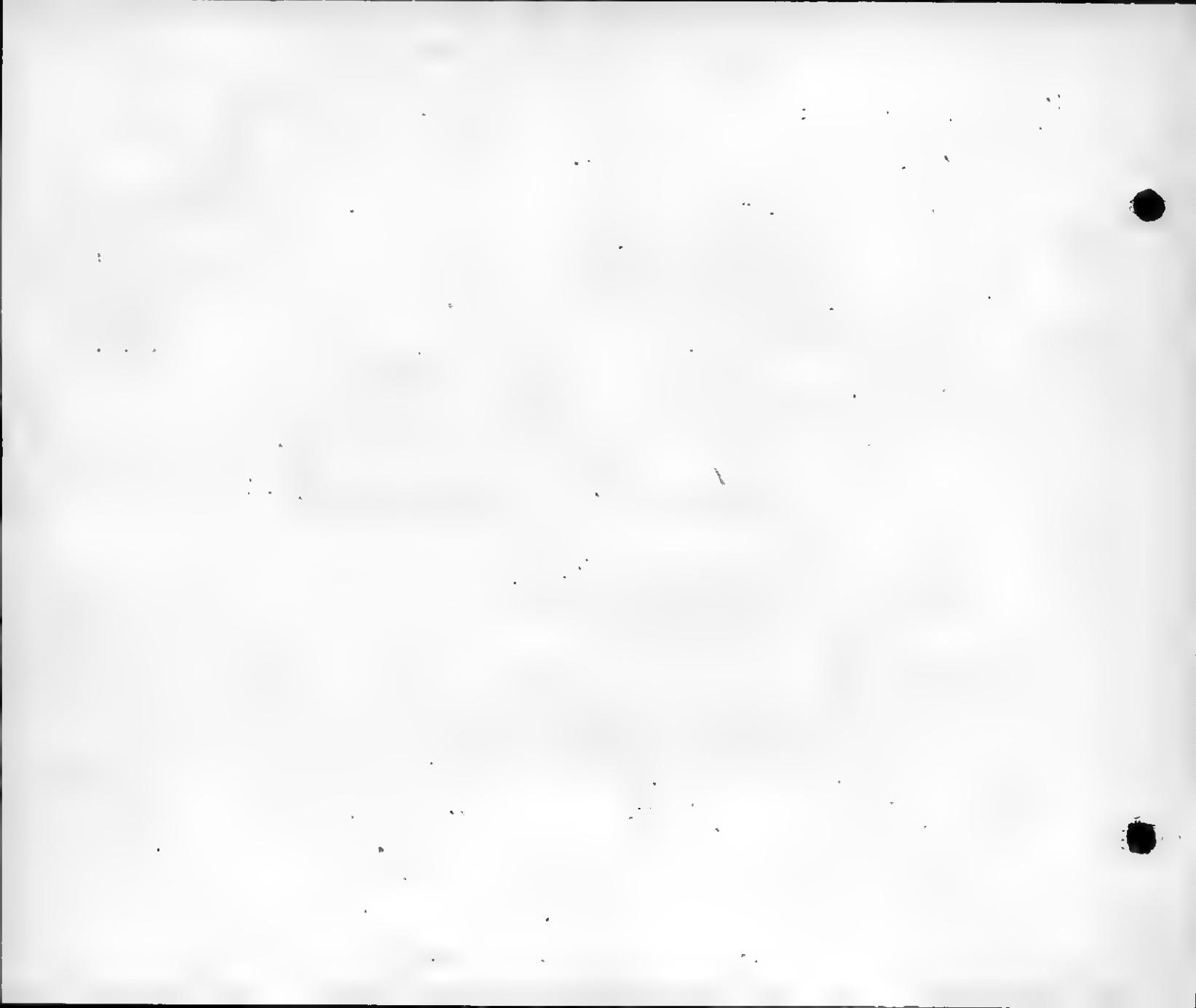
## CERTIFICATE OF DEATH

Reg. Dist. No.

00243

**TO ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN 1b <b>30 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>601 Morris Avenue (west)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Lula</b>	Middle <b>Hurley</b>	Last <b>Caulk</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>9</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18, 1870</b>
9. AGE (In years last birthday) <b>89</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	11. KIND OF BUSINESS OR INDUSTRY <b>---</b>	12. BIRTHPLACE (State or foreign country) <b>London, England</b>
13. FATHER'S NAME <b>Patrick Hurley</b>	14. MOTHER'S MAIDEN NAME <b>Kathleen Marley</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>-----</b>	INFORMANT <b>Cyril Caulk</b>	Address <b>601 W. Morris Avenue</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <i>Arteriosclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 9, 1960</b> , to <b>Jan 9, 1960</b> that I last saw the deceased alive on <b>Jan 9, 1960</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Lawrence C. Post</i>		ADDRESS (Street, city or town, state) <b>6805 York Rd. Baltimore 12, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Lawrence C. Post</b>		DATE SIGNED	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-12-'60</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Park</b>
22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>
VS A15 (4) ISM 9/58		Towson 4, Maryland JAN 14 '60	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0271 CERTIFICATE OF DEATH

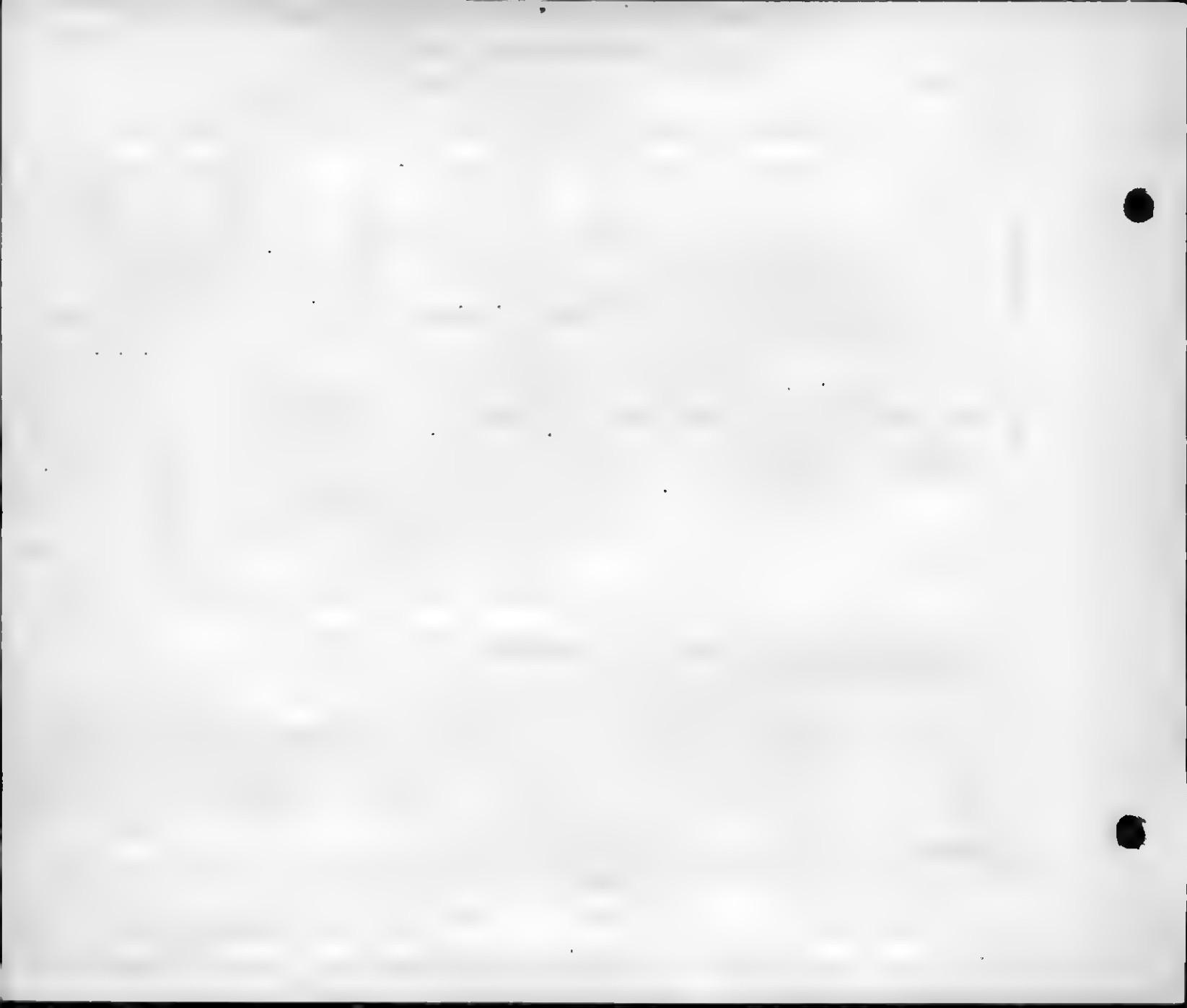
Reg. Dist. No.

00244

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55 Towson 4,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8524 Chestnut Oak Road</b>		e. STREET ADDRESS <b>8524 Chestnut Oak Road</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Blanche</b>	Middle <b>W</b>	Last <b>Chase</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>14</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <b>Dec. 2, 1871</b>	9. AGE (In years last birthday) <b>88 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Massachusetts</b>	11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Alfonso J. Wilder</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Rice</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <b>B. Wilder Chase, 8524 Chestnut Oak Road, Zone 4</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Generalized Arteriosclerosis 30 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis CVD</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 2, 1957</b> , to <b>1-14, 1960</b> , that I last saw the deceased alive on <b>5-6, 1960</b> , and that death occurred at <b>2 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Joseph F. Hillier M.D. 8400 North Haven Blvd., Baltimore, Md.</b>		DATE SIGNED <b>1/18/60</b>	
ACTUAL SIGNATURE <b>Joseph F. Hillier M.D.</b>		PHYSICIAN'S NAME (Type) <b>Joseph F. Hillier M.D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-16-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Moreland Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Taylor Avenue</b>	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Towson, Inc., 1050 York Road, Towson</b>		ADDRESS <b>1050 York Road, Towson</b>	
24a. REC'D BY REGISTRAR <b>JAN 18 1960</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Tracy</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0272

## CERTIFICATE OF DEATH

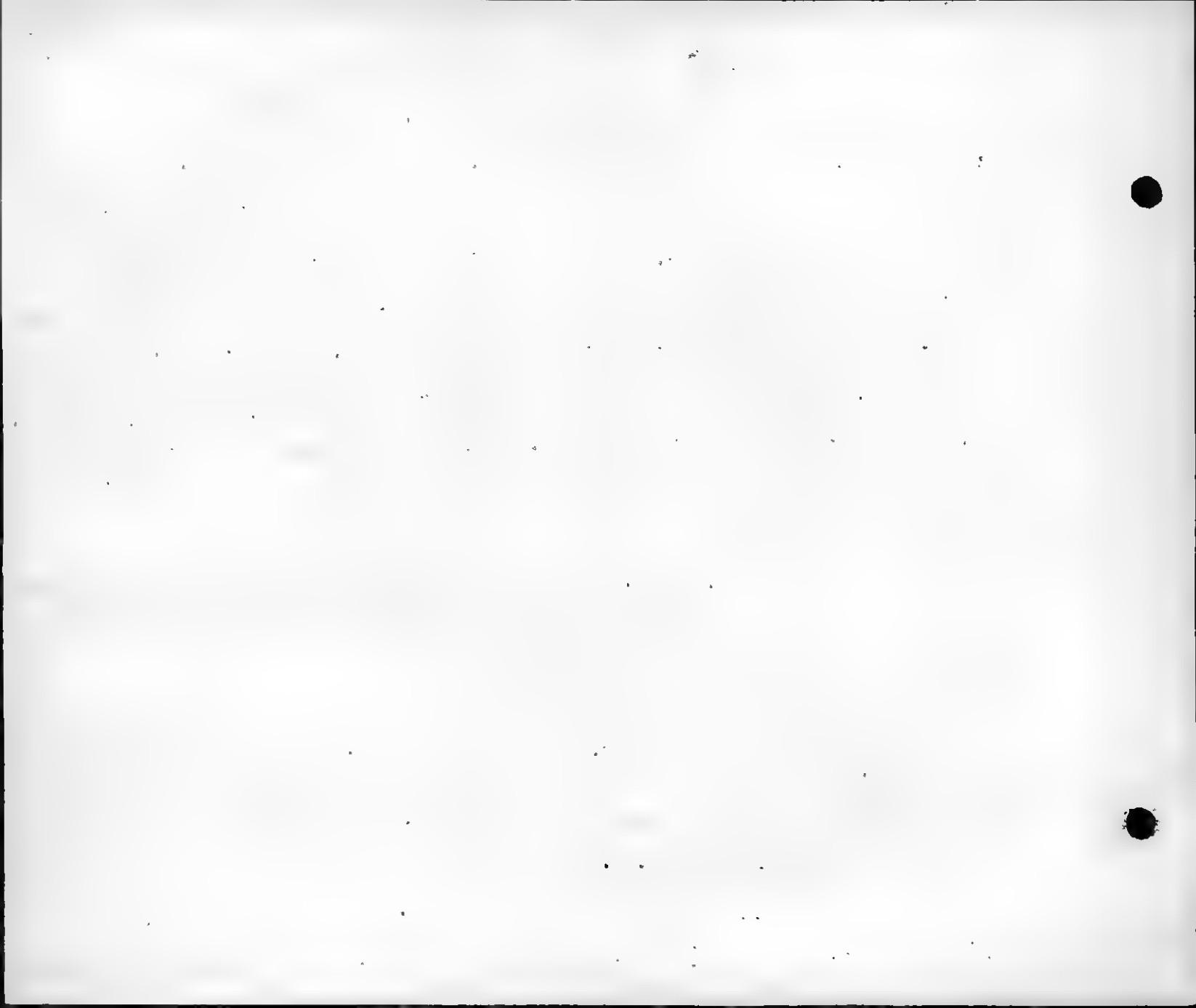
Reg. Dist. No.

00245

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event with n 72 hours after death.

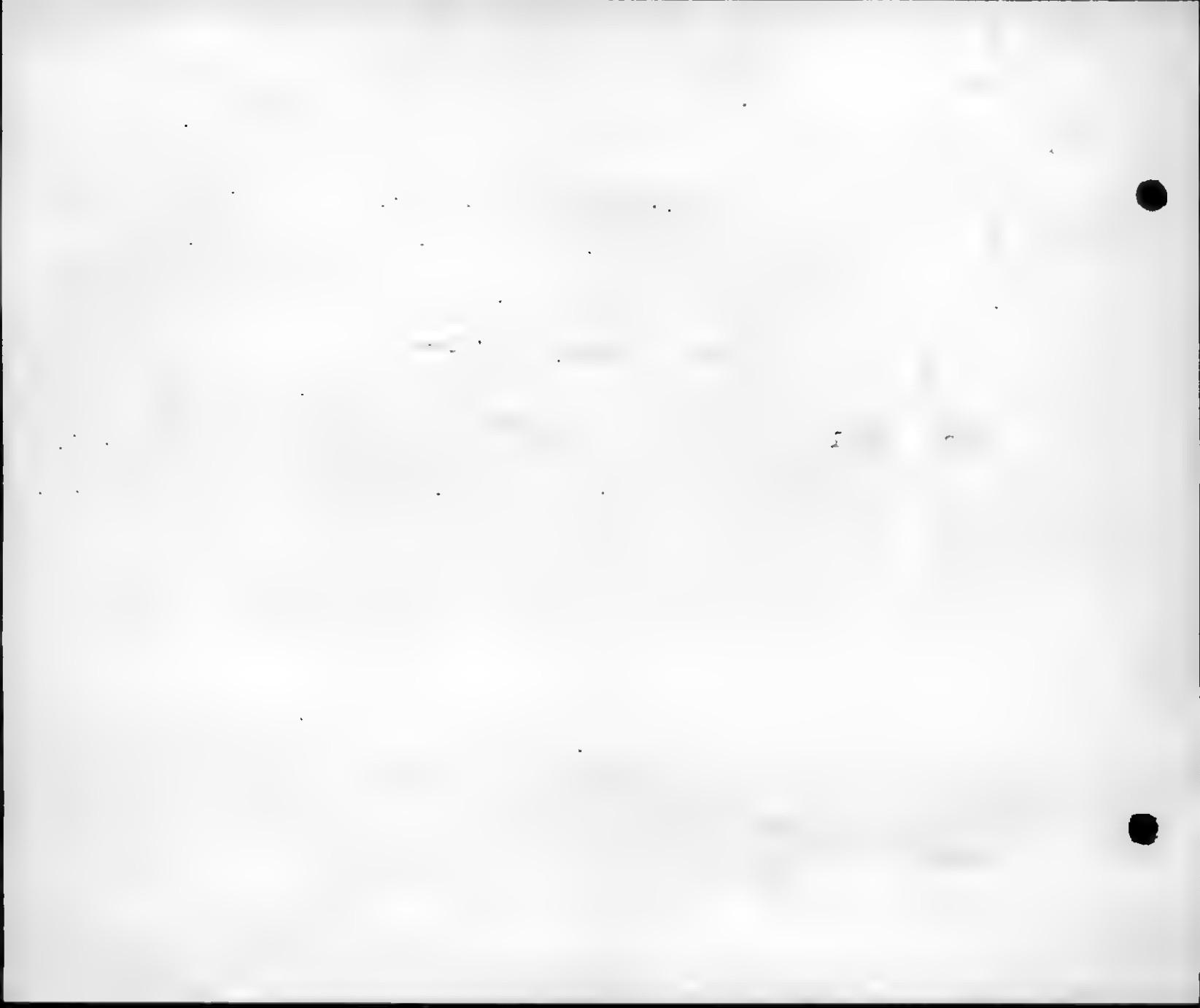
1. PLACE OF DEATH a. COUNTY <i>Baltimore City</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Maryland</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Ellicott City, Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore City</i>		c. LENGTH OF STAY IN 1b <i>Ellicott City</i>		d. STREET ADDRESS <i>1109 N. Calvert Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>N/A</i>									
3. NAME OF DECEASED (Type or print) <i>Naude</i>		First <i>M.</i>	Middle <i></i>	Last <i>Chenoweth</i>	4. DATE OF DEATH <i>January 26, 1960</i>	Month <i>Jan.</i>	Day <i>26</i>	Year <i>1960</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 6, 1882</i>		9. AGE (In years lost birthday) <i>77 yrs</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Ellicott City, Maryland U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Joshua Crusey</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Elizabeth Hainbright</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>100-00-0000</i>		INFORMANT <i>Ellicott City, Maryland</i>		17. INTERVAL BETWEEN ONSET AND DEATH <i>7/19/59</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]									
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Monocytic Leukemia</i>									
DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO (c) <i>Hypertensive Cardio-vascular disease</i>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>Feb. 11, 1958</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Ellicott City</i>		(County) <i>Howard County</i>	(State) <i>Maryland</i>
21. I certify that I attended the deceased from <i>Feb. 11, 1958</i> , to <i>Jan. 23, 1960</i> , that I last saw the deceased alive on <i>Jan. 23, 1960</i> , and that death occurred at <i>3:00 a.m.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>1109 N. Calvert Street, Baltimore 2, Maryland</i>									DATE SIGNED <i>1/26/60</i>
ACTUAL SIGNATURE <i>Harry Kelmenson</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>Harry Kelmenson, M. D.</i>		Baltimore 2, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan. 29, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>David Ridge Cemetery</i>		22d. LOCATION (City, town, or county) <i>Ellicott City, Md.</i>		(State) <i>Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Frank J. Klemenson</i>		ADDRESS <i>1109 N. Calvert Street, Baltimore 2, Maryland</i>		24a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>			
				DATE JAN 29 '60					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												00246	
CERTIFICATE OF DEATH												Reg. Dist. No.	
1. PLACE OF DEATH o. COUNTY		BALTIMORE		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)		o. STATE		MD.		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town)		CATONSVILLE		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		BALTO.					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		SUMMIT NURS. HOME, 98 SMITHWOOD AVE		d. STREET ADDRESS		2871 AISQUITH ST.		e. IS RESIDENCE ON A FARM?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		WILLIAM H. CLAMPITT		First Middle Last		4. DATE OF DEATH		Month		Day		Year	
5. SEX		M. W.		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
						MAY 24, 1895		64 yrs.		Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
				URBAN LAUNDRY		Maryland		USA.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME											
CLAMPITT		UNKNOWN											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		Yes WW I		16. SOCIAL SECURITY NO.		INFORMANT		Address					
				215-05-5595		HARRY W. CLAMPITT		3 DAY DR, BOWLEY'S QUARTERS, BALTO., MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Lobar pneumonia 2 days											
490X		DUE TO		(b)		(c)							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
C.V.A.													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
19													
21. I certify that I attended the deceased from alive on Jan 29, 1960, and that death occurred at 1108 M. from the causes and on the date stated above		August 1959, to Jan 29, 1960											
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)										DATE SIGNED	
PHYSICIAN'S NAME (Type)		1709 Edgewood Ave, Baltimore, Md.										Jan 30, 1960	
22a. BUR. A. CREMATION OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)					
BURIAL		FEB. 1, 1960		BALTIMORE CEMETRY		BALTO. MD.							
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
WITZKE FUNERAL DIR. 4101 EDMONDSON AVE.				DATE FEB 1 '60		Curtis S. Turner							
VS A15 (4) ISM 9/58													



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

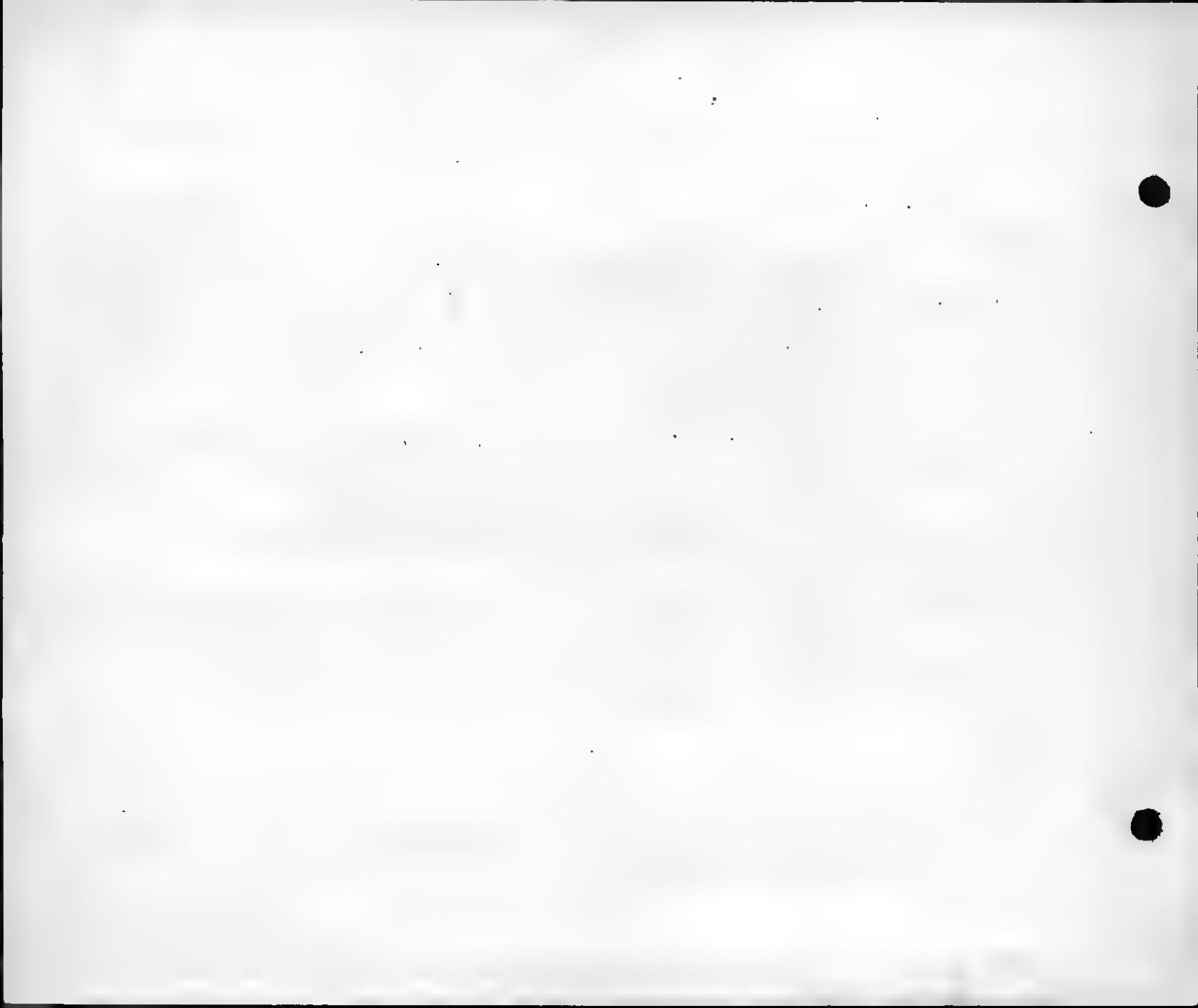
## 0274 CERTIFICATE OF DEATH

Reg. Dist. No.

00247

**TO HOSPITAL** or attending physician: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE	
<b>BALTIMORE MARYLAND</b>		<b>MARYLAND BALTIMORE</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY	
RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ARMAGOST NURSING HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE 3 VO.</b>	
3. NAME OF DECEASED (Type or print) <b>OLIVIA FENDALL CLEMENS</b>		4. DATE OF DEATH <b>JAN 28 1960</b>	Month Day Year
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1888</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		9. IF UNDER 1 YEAR Months Days Hours Min.	10. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Towson, Balt Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Fendall</b>		14. MOTHER'S MAIDEN NAME <b>Street</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>no - Mr Lenny B. Clemens - same</b>	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>14 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20g. ADDRESS (Street, city or town, state)		20h. DATE SIGNED	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>60</b> , to <b>Jan 28</b> , 19 <b>60</b> that I last saw the deceased alive on <b>Jan 27</b> , 19 <b>60</b> , and that death occurred at <b>6:10 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Frederick J. Vollmer</b>		M.D. <b>600 York Rd</b>	
PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>		ADDRESS <b>Baltimore-12, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/30/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Rock Spring Church Cemetery</b>
22d. LOCATION (City, town, or county) <b>Hayford, Co., Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry W. Jenkins &amp; Sons Co.</b>		24a. RECEIVED BY REGISTRAR DATE <b>FEB 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Trahan</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0275 CERTIFICATE OF DEATH

Reg. Dist. No. 10248

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admis on) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>31 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>5306 York Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>E.</b>	Last <b>COALE</b>	4. DATE OF DEATH <b>January 4, 1960</b>	Month <b>January</b>	Day <b>4</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1890</b>	9. AGE (In years last birthday) yrs <b>69</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tavern</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John H. Coale</b>				14. MOTHER'S MAIDEN NAME <b>Sally F. Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>216-09-1143</b>		INFORMANT <b>Clin. Records VAH Balto., Md., Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>LAENNEC'S CIRRHOSIS OF LIVER</b> XOXO TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>HEPATOMA OF LIVER</b> DOKCK } (c) <b>GENERALIZED ARTERIOSCLEROSIS</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH <b>11 YEARS</b>							
UNKNOWN							
UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that / attended the deceased from <b>December 4, 1959</b> to <b>January 4, 1960</b> , and that death occurred at <b>6:00 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Armen Bogosian</b> DATE SIGNED <b>1/5/60</b>							
ACTUAL SIGNATURE <b>Armen Bogosian</b> M.D. VAH Balto., Md., Ft. Howard Div. 1/5/60							
PHYSICIAN'S NAME (Type) <b>ARMEN BOGOSIAN, M.D.</b> VAH Balto., Md., Ft. Howard Div. 1/5/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) <b>Frederick Ave., Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Wm Cook-Bright, Inc. 6009 Harford Rd.</b>							
				24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	
WM. COOK-BRIGHT, INC. 6009 HARFORD RD., BALTO., MD.							

CCU 12

**TO HOSPITAL**: The law requires that the death certificate be executed within 24 hours after death. Page 4  
**by the hospital or attending physician.**

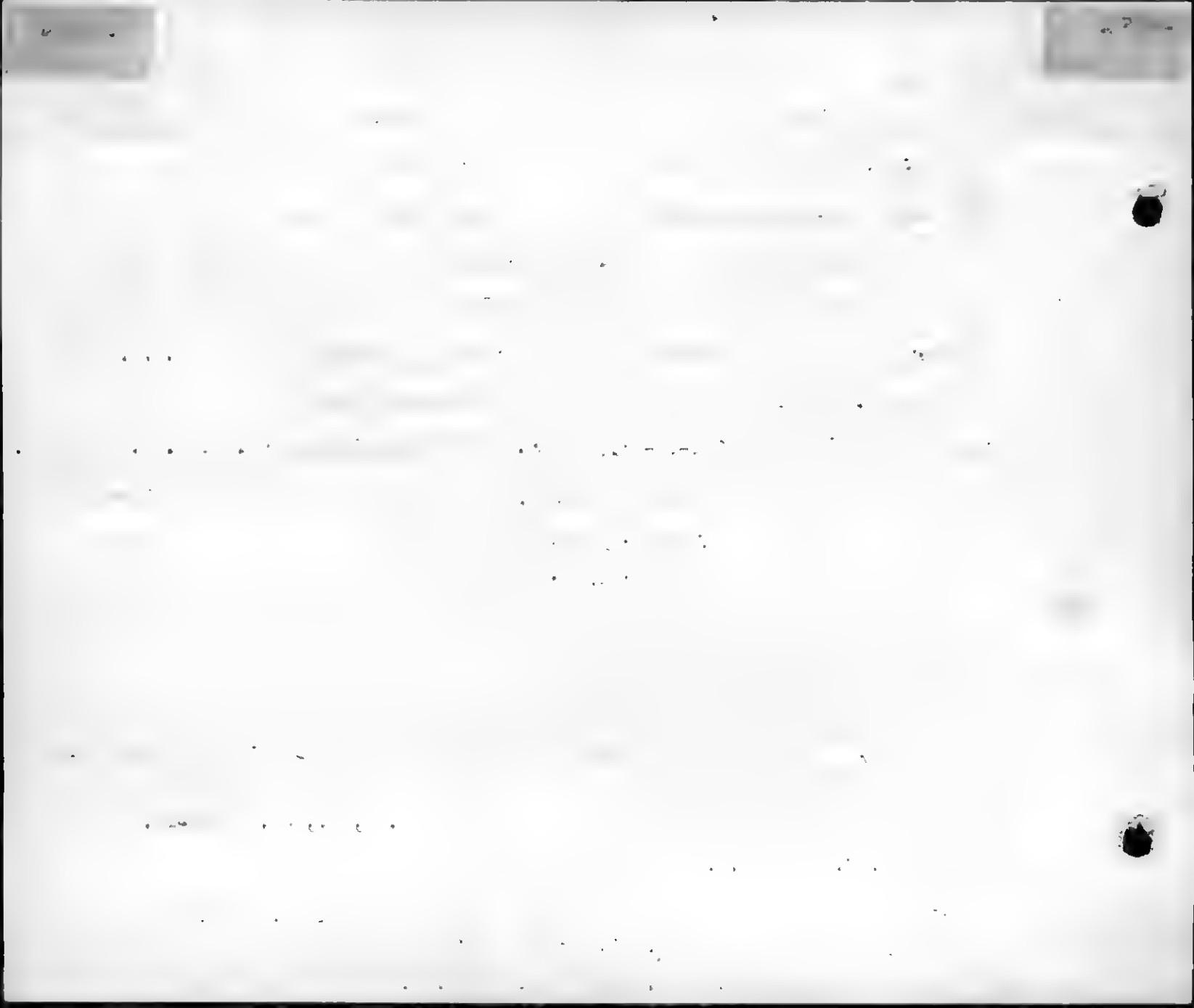
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0276 CERTIFICATE OF DEATH

Reg. Dist. No. 00249

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<b>Baltimore</b>				a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>11 days</b>		b. COUNTY	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. STREET ADDRESS <b>4001 Annen Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>SAMUEL</b>	Middle <b>E.</b>	Last <b>COLLINS</b>	4. DATE OF DEATH <b>January 23</b>	Month Day Year 19 60
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>4/10/90</b>	9. AGE (In years last birthday) <b>69 yrs</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General</b>		11. BIRTHPLACE (State or foreign country) <b>Elkridge, Maryland</b>	
13. FATHER'S NAME <b>John H. Collins</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Turner</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212-03-8137</b>		INFORMANT <b>Clin. Records VA Hospital, Balto. 18, Md. Ft. Howard Div.</b>	
17. INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>		18. DUE TO <b>BRONCHOPNEUMONIA, BILATERAL</b>			
19. HOURS <b>Hours</b>		20. DUE TO <b>EDEMA OF LUNGS</b>			
21. DUE TO <b>GENERALIZED ARTERIOSCLEROSIS</b>		22. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that <b>I</b> attended the deceased from <b>January 12, 1960</b> , to <b>January 23, 1960</b> , and that death occurred at _____ M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <b>C. B. Cope</b>		M.D. <b>VA Hospital, Baltimore, Md., Ft. Howard Div.</b>		DATE SIGNED <b>1/24/60</b>	
PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-24-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Good Samaritan Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Elkridge, Maryland</b>				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Eroy Wilson 601 W. Hamburg St.</b>		ADDRESS <b>601 W. Hamburg St.</b>		24a. REC'D BY REGISTRAR DATE JAN 27 '60	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. Price</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be reburied by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, removal, or cremation.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

00250

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>16</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Home</i>		52. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
e. STREET ADDRESS <i>403 Glenmore Ave.</i>		52. d. STREET ADDRESS <i>Forest Haven Home</i>	
3. NAME OF DECEASED (Type or print) <i>John Colondrillo</i>		First <i>J</i>	Middle <i>H</i>
4. DATE OF DEATH <i>Jan 14 1960</i>		Last <i>J</i>	Month <i>Jan</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>10/16/67</i>		9. AGE (in years last birthday) <i>91</i>	10. IF UNDER 1 YEAR Months <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Gardener</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>ret.</i>	11. BIRTHPLACE (State or foreign country) <i>Italy</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>unknown</i>	
14. MOTHER'S MAIDEN NAME <i>unknown</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>[Redacted]</i>		17. INFORMANT <i>Hospital records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>PULMONARY EDEMA</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>PROFOUND SLENOGRAM CARBON</i> (c) <i>VASCULAR DISEASE</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) (we) last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above		22b. DATE SIGNED <i>1/15/60</i>	
22a. SIGNATURE <i>John H. Shaw</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>John H. Shaw M.D.</i>		22d. ADDRESS <i>6800 Edgewood Rd. At 28</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-16-60</i>	
23c. NAME OF CEMETERY OR CREMATORIUM <i>London Park Cemetery Baltimore</i>		23d. LOCATION (City, town, or county) (State) <i>Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McNabb &amp; Son</i>		ADDRESS <i>28</i>	
25a. REG'D. BY REC. STAR DATE <i>JAN 18 1960</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Evans</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 0278 CERTIFICATE OF DEATH

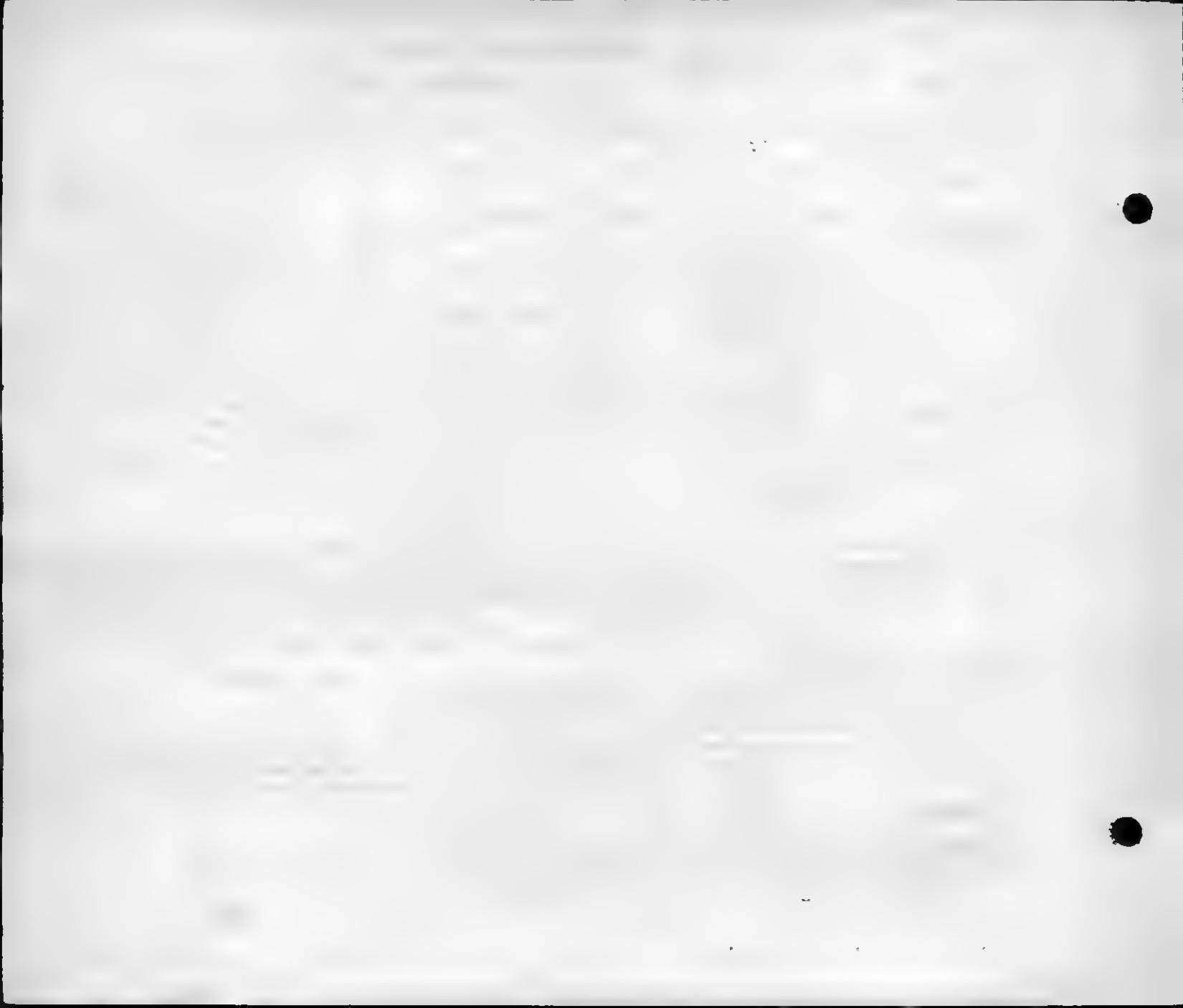
Reg. Dist. No.

00251

1. PLACE OF DEATH o COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE MARYLAND b. COUNTY			
BALTIMORE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
COCKEYEVILLE	9 MONTHS	CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS				
MASONIC HOME	530 MECHANIC ST.				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First	Middle	Last		
THOMAS JONES		CONNOR			
4. DATE OF DEATH	Month	Day	Year		
JAN	3		1960		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		
MALE	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	3-1-1883		
9. AGE (In years lost birthday) 76 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
BAKER		MARYLAND	U. S.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME				
THOMAS C. CONNOR	JANET JONES				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address		
NO	236-42-0265	Frank L. Smith Jr.	Cockeysville, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]	INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Cardio</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Vascular Disease</i> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased from <u>3-6</u> , 1959, to <u>i-2</u> , 1960, that I last saw the deceased alive on <u>i-2</u> , 1960, and that death occurred at <u>10:15 PM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE		M.D.		ADDRESS (Street, city or town, state)	
<i>Walter F. Kees</i>				DATE SIGNED <u>1/3/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town or county)	
REMOVAL		1-4-60	Hillcrest Cemetery	(State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE			ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
Wm. Cook, Inc., 1217 St. Paul Street				DATE JAN 5 '60	<i>Chileng &amp; Kees</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C L55 10M

**MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**

Item 22 FilmG255 1-28-60 et

01252

**CERTIFICATE OF DEATH**

0279

Reg. Dist. No. 32

**1. PLACE OF DEATH**

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL  
OR and give nearest town)

TOWN Mt. Wilson

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Mt. Wilson State Hospital

MARYLAND

LENGTH OF STAY  
(In this place)

20 MONTHS

**2. USUAL RESIDENCE (HOME) OF DECEASED**

STATE MARYLAND COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

BALTIMORE

STREET  
ADDRESS

(If rural give location)

442 N. MONFORD AVENUE

**3. NAME OF  
DECEASED**

(Type or Print)

JOHN

JAMES

CONRAD

(First)

(Middle)

(Last)

**4. DATE  
OF  
DEATH**

(Month)

(Day)

(Year)

1 - 23 - 1960

**5. SEX**

MALE

6. COLOR OR  
RACE

WHITE

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

PAINTER

(Specify)

WIDOWED

10b. KIND OF BUSINESS  
OR INDUSTRY

PAINTING

(Specify)

11. BIRTHPLACE (State or foreign country)

ILLINOIS

(Specify)

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

(Specify)

13. FATHER'S NAME

JOSEPH CONRAD

(Specify)

14. MOTHER'S MAIDEN NAME

MARY BERRANS

(Specify)

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unk.)

(If Yes, give war or dates of service)

NO

(Specify)

16. SOCIAL SECURITY NO.

215-01-0383

(Specify)

17. INFORMANT &amp; ADDRESS

Hospital Records

(Specify)

Mt. Wilson State Hospital

(Specify)

18. MEDICAL CERTIFICATION

IMMEDIATE CAUSE

(A) PULMONARY TUBERCULOSIS, MODERATELY ADVANCED

ANTECEDENT CAUSE(S) DUE TO

(B) \_\_\_\_\_

DISEASES OR CONDITIONS, IF ANY,

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST,

DUE TO

(C) \_\_\_\_\_

INTERVAL BETWEEN  
ONSET AND DEATH

1 3/4 YEARS

(Specify)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

(Specify)

20. AUTOPSY?

YES  NO 

(Specify)

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH

(If either, NOTIFY MEDICAL EXAMINER)

(Specify)

21b. PLACE (Home, farm, factory,

OR INJURY street, office bldg., etc.)

(Specify)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

(Specify)

21d. TIME OF INJURY (Month)

(Day)

(Year)

(Hour)

21e. INJURY OCCURRED

While

at work 

Not while

at work 

(Specify)

21f. HOW DID INJURY OCCUR?

(Specify)



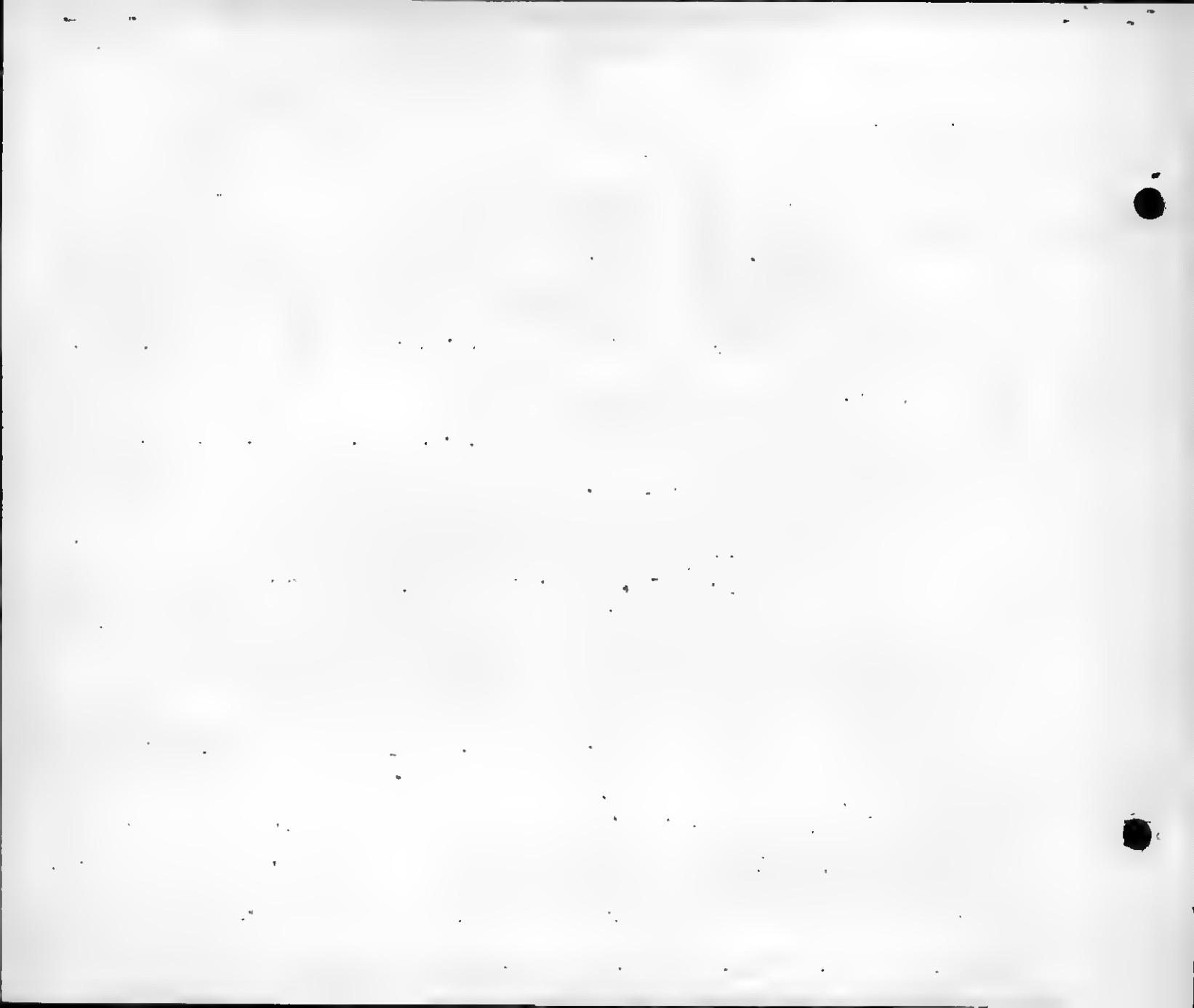
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00253

## CERTIFICATE OF DEATH

Reg Dist No

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution- Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>1 Day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3vo: t		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1505 Covington Street (3)</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>CHARLES</b>		First <b>R.</b>	Middle <b>L.</b>	Last <b>CONWAY</b>	4. DATE OF DEATH <b>January</b>	Month <b>January</b>	Day <b>5</b>	Year <b>1960</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>January 2, 1893</b>	9. AGE (In years less birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>K U. S. A.</b>		
13. FATHER'S NAME <b>Joseph B. Conway</b>				14. MOTHER'S MAIDEN NAME <b>Emma Myers</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>	Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>ACUTE CORONARY OCCLUSION</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>OLD CORONARY OCCLUSION WITH OLD MYOCARDIAL INFARCTION</b> (b) <b>UNKNOWN</b> (c) <b>UNKNOWN</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 HR UP</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>UNKNOWN</b>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c TIME OF INJURY Hour o.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	20f (City or town) <b>1/6/60</b>	(County)	(State)		
21. I certify that I attended the deceased from <b>January 4, 1960</b> , to <b>January 5, 1960</b> , and that the deceased was alive on <b>January 4, 1960</b> , and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b> DATE SIGNED <b>1/6/60</b>								
ACTUAL SIGNATURE <i>John W. Crawford</i>		PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/6/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James L. McCullly</b>		ADDRESS <b>128 E. Fort St., Baltimore, Md.</b>	24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>	24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

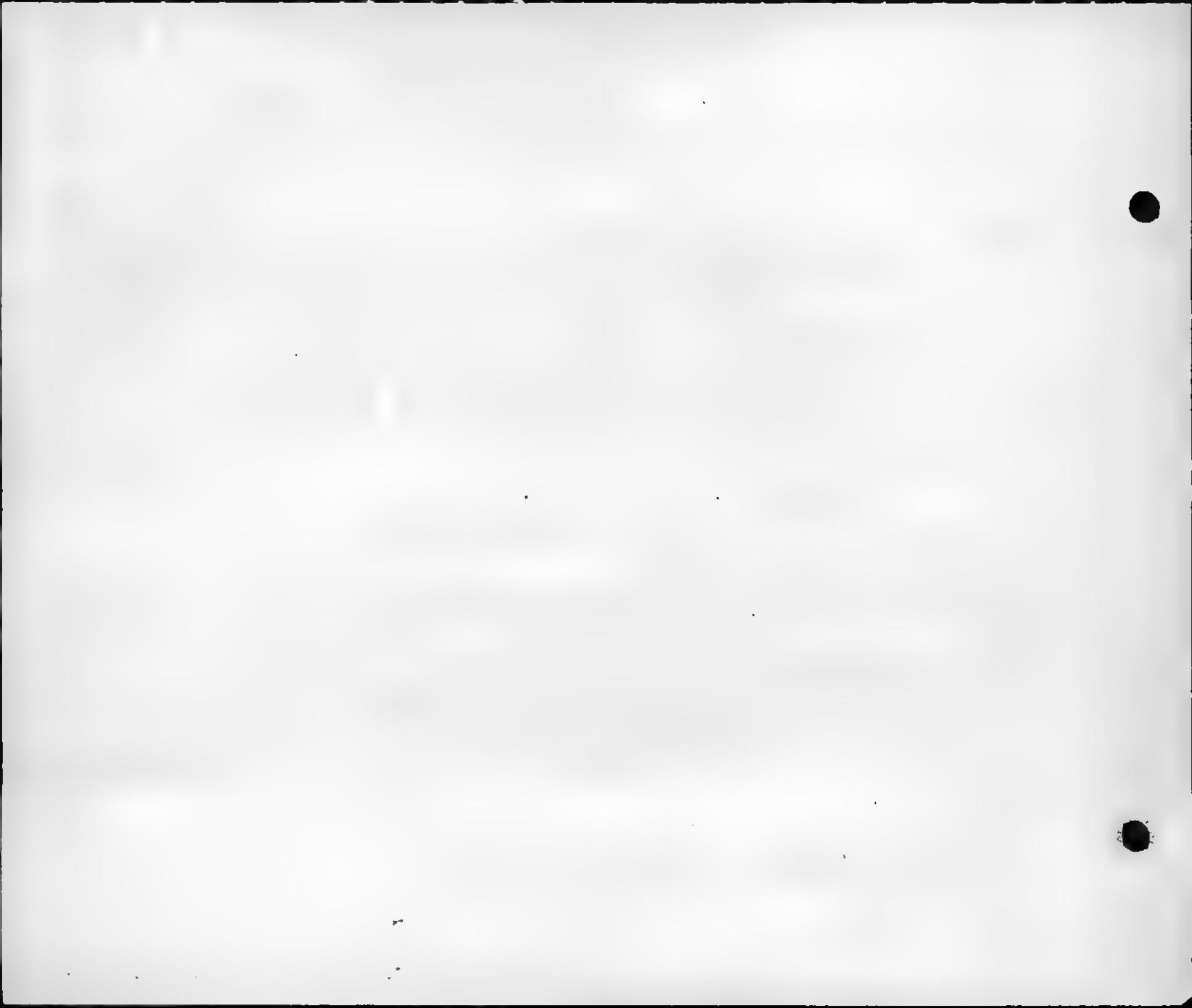
110254

## 0281 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>MD.</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WHITE HALL</b>		c. LENGTH OF STAY IN lb RURAL and give nearest town) <b>X RURAL</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b></b>		e. STREET ADDRESS <b></b>				
3. NAME OF DECEASED (Type or print) <b>IZORA EVELYN COXNETT</b>		4. DATE OF DEATH <b>JAN 28</b>	Month Day Year 1960			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-21-1880</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	11. BIRTHPLACE (State or foreign country) <b>FLAT RIDGE, VA.</b>			
13. FATHER'S NAME <b>GEORGE PARKS</b>		14. MOTHER'S MAIDEN NAME <b>VINNIE TESTERMAN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>	17. INFORMANT <b>Floyd Cox</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arterio-sclerotic Cardiovascular disease</b>		Address <b>White Hall Rd #2 2nd</b>				
DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Doy, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) <b>Perkins, Md.</b>	(County) <b>—</b>	(State) <b>—</b>
21. I certify that I attended the deceased from <b>Jan. 27</b> , 1960, to <b>Jan. 28</b> , 1960, that I last saw the deceased alive on <b>Jan. 27</b> , 1960, and that death occurred at <b>10 AM</b> , from the causes and on the date stated above.						
ACTUAL SIGNATURE <b>A. M. France</b>		ADDRESS (Street, city or town, state) <b>Perkins, Md.</b>		DATE SIGNED <b>1/29/60</b>		
PHYSICIAN'S NAME (Type) <b>A. M. FRANCE</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-31-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>NEW BETHAL BAPTIST STEWARTSBURG YORK Co. Pa.</b>	22d. LOCATION (City, town, or county) (State) <b>—</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth W. Busby, Stewartstown, Pa.</b>		ADDRESS <b>—</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



TO HOSPITAL  TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**CERTIFICATE OF DEATH**

Reg. Dist. No. 00255

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>		e. STREET ADDRESS <b>201 Montrose Ave.</b>					
3. NAME OF DECEASED (Type or print) <b>ELLA</b>		First <b>GRACE</b>	Middle <b>COX</b>				
4. DATE OF DEATH <b>January 17 1960</b>		Month <b>January</b>	Day <b>17</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <b>Aug. 24, 1873</b>		9. AGE (In years last birthday) <b>86 yrs.</b>	10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY					
11. BIRTHPLACE (State or foreign country) <b>Baltimore Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Luther Timanus</b>		14. MOTHER'S MAIDEN NAME <b>Mary George</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>Mrs. Margaret G. Respass-201 Montrose Ave.</b>		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)							
450.0 DUE TO <b>Pulmonary Edema</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arterio Sclerosis</b> year -							
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <b>1118 St. Paul St.</b>		(County) <b>Randallstown</b>	(State) <b>Maryland</b>
21. I certify that I attended the deceased from <b>August 1946</b> , to <b>1-11 1960</b> , and that I last saw the deceased alive on <b>1-17 1960</b> , and that death occurred at <b>4 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>1118 St. Paul St.</b>		DATE SIGNED <b>1/19/60</b>	
ACTUAL SIGNATURE <b>Wetherbee Fort</b>							
PHYSICIAN'S NAME (Type) <b>Wetherbee Fort, M.D.</b>				1118 St. Paul Street			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/21/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Mt. Olive Cemetery</b>		22d. LOCATION (City, town, or county) <b>Randallstown</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John W. Wetherbee</b>				ADDRESS <b>4600 Liberty Heights Ave.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	
						24b. REGISTRAR'S SIGNATURE <b>John W. Wetherbee</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be retained by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0283

**CERTIFICATE OF DEATH**

00256

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belleville</i>		c. LENGTH OF STAY IN 1b <i>1 year</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Belleville</i>		d. STREET ADDRESS <i>206 Belmont Ave.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Holy Cross Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>LIDA C. CRAMBLITT</i>		First <i>LIDA</i>	Middle <i>C.</i>	Last <i>CRAMBLITT</i>	4. DATE OF DEATH <i>Jan 2 1960</i>	Month <i>Jan</i>	Day <i>2</i>	Year <i>1960</i>	
S SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9/25/1885</i>		9. AGE (in years last birthday) <i>74 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS Days <i>0</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Waitress</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>at home</i>		11. BIRTHPLACE (State or foreign country) <i>Tenn.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>John Taylor</i>		14. MOTHER'S MAIDEN NAME <i>unknown in records</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT <i>Robert Cramblitt</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO <i>Myocardial Insufficiency</i>				INTERVAL BETWEEN ONSET AND DEATH <i>2 months</i>			
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO		(b) <i>Coronary arteritis</i>				10 days			
		(c) <i>Generalized arteriosclerosis</i>				15 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6209 Frederick Ave, Balt. 28, Md.</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>Md</i>
21. I certify that (I) (this hospital) attended the deceased from <i>4-6 1960</i> to <i>1-2-1960</i> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>1-1-1960</i> , and that death occurred at <i>530 M</i> , from the causes and on the date stated above.									
22a. SIGNATURE <i>William K. Gallagher</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22b. DATE SIGNED <i>1-3-60</i>			
22c. PHYSICIAN'S NAME (Type) <i>William K. Gallagher</i>		22d. ADDRESS <i>6209 Frederick Ave, Balt. 28, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1/4/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>London Park</i>		23d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>McNaughton</i>		ADDRESS <i>28</i>				25a. REC'D BY REGISTRAR DATE JAN 5 '60		25b. REGISTRAR'S SIGNATURE <i>Charles E. Kline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

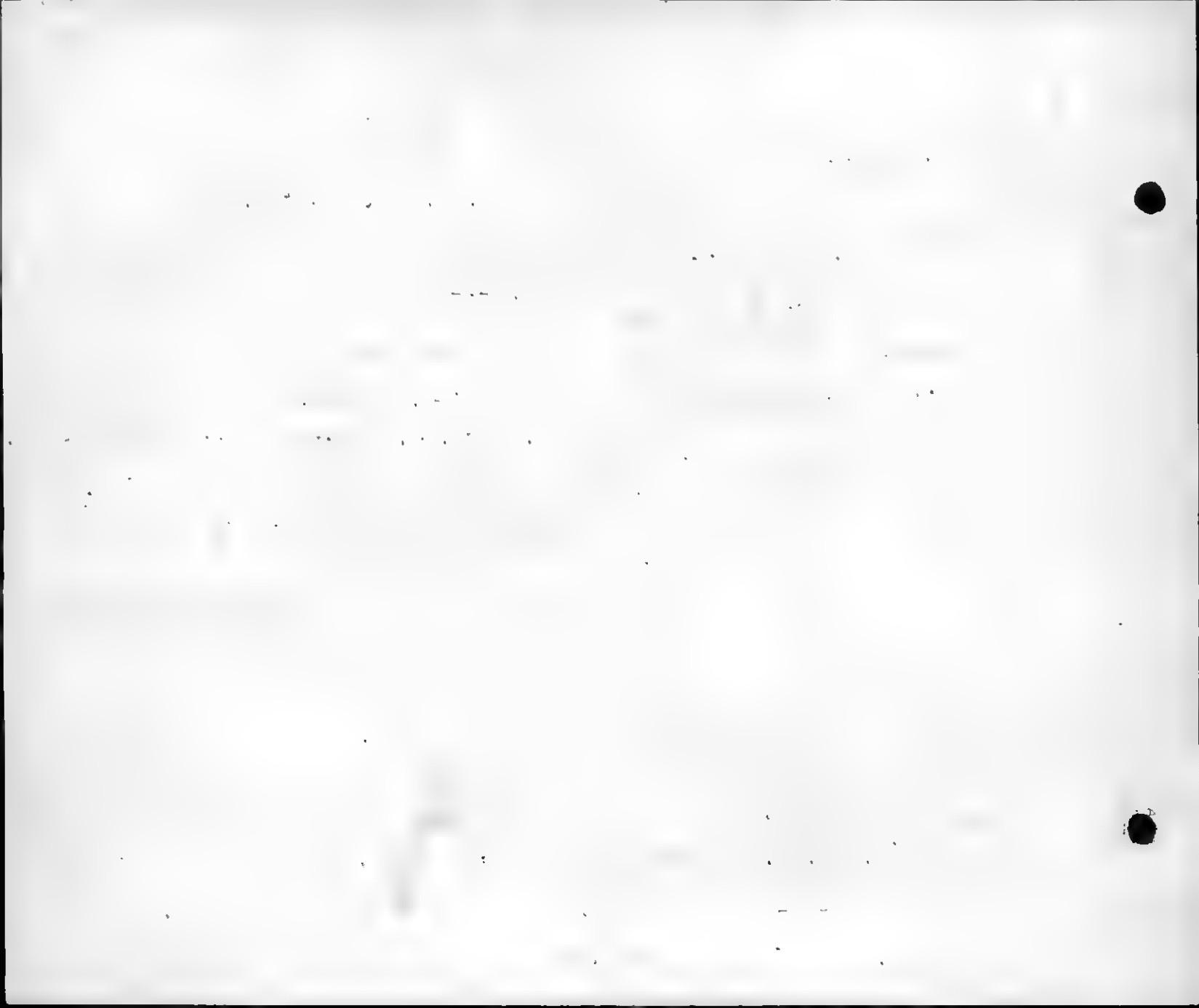
## 0284 CERTIFICATE OF DEATH

Reg. Dist. No. 00257

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i></i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House in the Pines</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mrs.</i>	Middle <i>Laura</i>	Last <i>Creamer</i>
S. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-2-1882</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
13. FATHER'S NAME <i>Frederick Winterling</i>		14. MOTHER'S MAIDEN NAME <i>Mary Seeberger</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	INFORMANT <i>Mr. Fred. W. Creamer</i>
			Address <i>1113 Longbrook Rd.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Armenia</i>			
4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Disease</i> DUE TO <i>Armenia</i> 3 months			
5. (c) <i>Disease</i> DUE TO <i>Armenia</i> 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>	
21. I certify that I attended the deceased from <i>12/1/1960</i> to <i>1/1/1960</i> , that I last saw the deceased alive on <i>1/1/1960</i> , and that death occurred at <i>1/1/1960</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>E. W. Johnson</i>		ADDRESS (Street, city or town, state) <i>3432 Frederick Road</i>	
DATE SIGNED <i>1/11/60</i>			
PHYSICIAN'S NAME (Type) <i>Dr. E. W. Johnson</i>		Baltimore, Maryland	
22a. BURIAL, CREMATON, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-14-60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Road #14</i>		ADDRESS <i></i>	
		24a. REC'D BY REGISTRAR DATE <i>JAN 13 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

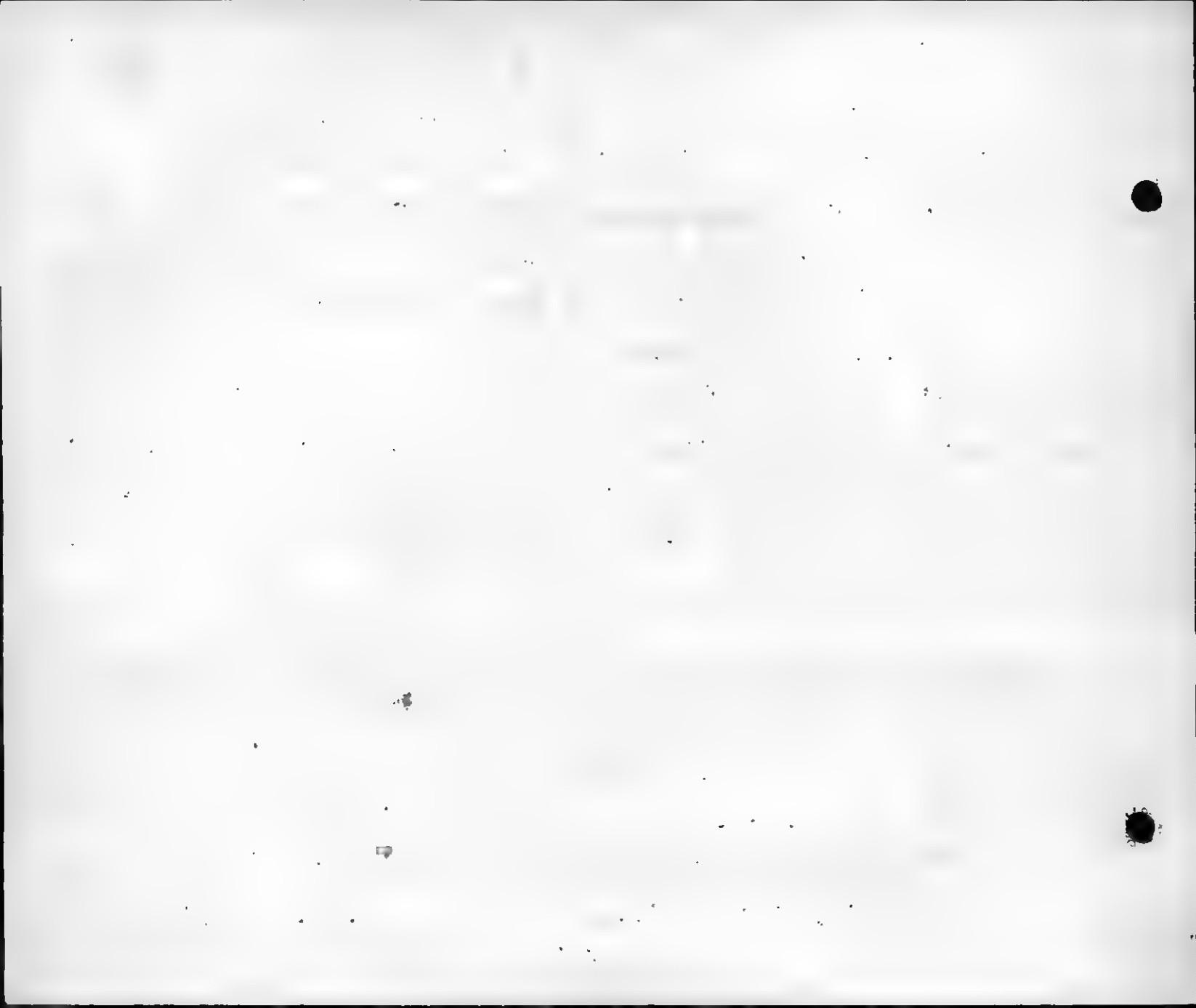
## 0285 CERTIFICATE OF DEATH

Reg. Dist. No.

00258

**TO HOSPITAL** or **ATTENDING PHYSICIAN**: The law requires that the death certificate be executed within 24 hours after death. It may be referred to the hospital or attending physician.  
**TO FUNERAL DIRECTOR**: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) o. STATE	
BALTIMORE, MARYLAND		MARYLAND BALTO-	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL Govans	2 WEEKS	4920 HARFORD ROAD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
ARMACOST NURSING HOME	4920 HARFORD ROAD		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
LULA			CROWDER
4. DATE OF DEATH	Month	Day	Year
JAN	20	1960	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	WHITE	SEPT. 25, 1870	9. AGE (In years lost birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWIFE		HOUSEWIFE	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
BALTO. Co.		USA.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
CHARLES H CROWDER		SUSAN R ERDMAN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO.	
No		None	
INFORMANT		Address	
WICHESTER KNOX 2904 SOUTHERN AVE.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):  Due to cerebral Hemorrhage		2 mos.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b):  Due to cerebral Arteriosclerosis		2 yrs.	
(c):			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 8, 1959, to Jan 20, 1960, that I last saw the deceased alive on Jan 20, 1960, and that death occurred at 75th St, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE		DATE SIGNED	
GEORGE SAWYER M.D.		Breck 14-2nd 1/21/60	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		JAN 23, 1960	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)	
PROSPECT HILL CEM.		BALTO. MARYLAND.	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS #6	
Lassahn Funeral Home 7401 Belair Rd		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
		24b. REGISTRAR'S SIGNATURE	
		Arthur S. Kraus	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0230 CERTIFICATE OF DEATH**

00259

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN 1b <i>20 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Halethorpe</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>3327 James St.</i>		d. STREET ADDRESS <i>3327 James St.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Angela M. Cummings</i>		First <i>A</i>	Middle <i>M.</i>
4. DATE OF DEATH <i>January 2 1960</i>		Month <i>January</i>	Day <i>2</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Own Home</i>
8. DATE OF BIRTH <i>June 7 1911</i>		9. AGE (In years last birthday) <i>48 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <i>4</i> Days <i>0</i> Hours <i>0</i> Min. <i>Maryland</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Andrew Monganelli</i>		14. MOTHER'S MAIDEN NAME <i>Josephine Liberto</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Henry M. Cummings 3327 James St.</i>	
17. INFORMANT <i>Address</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>metastatic carcinoma</i>		INTERVAL BETWEEN ONSET AND DEATH <i>7 months</i>	
19a. CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST.  (b) <i>serious carcinoma of breast</i>		20. DUE TO  (c) <i>20 months</i>	
21. I certify that I attended the deceased from <i>12/29</i> , 19 <i>57</i> , to <i>1/2</i> , 19 <i>60</i> that I last saw the deceased alive on <i>1/2</i> , 19 <i>60</i> , and that death occurred at <i>3:20 P.M.</i> from the causes and on the date stated above		22. ADDRESS (Street, city or town, state) <i>ADDRESS (Street, city or town, state)</i>	
ACTUAL SIGNATURE <i>Paul R. Ziegler</i>		DATE SIGNED <i>DATE SIGNED</i>	
PHYSICIAN'S NAME (Type) <i>PAUL R. ZIEGLER M.D.</i>		23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
24. DATE THEREOF <i>1/6/60</i>		25. NAME OF CEMETERY OR CREMATORIUM <i>ADDRESS</i>	
26. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)	
27. FUNERAL DIRECTOR'S SIGNATURE <i>Anthon, Inc. 1328 Sulfur Spring Rd.</i>		28. REC'D BY REGISTRAR DATE JAN 6 '60	
		29. REGISTRAR'S SIGNATURE <i>Arthur S. Traub</i>	



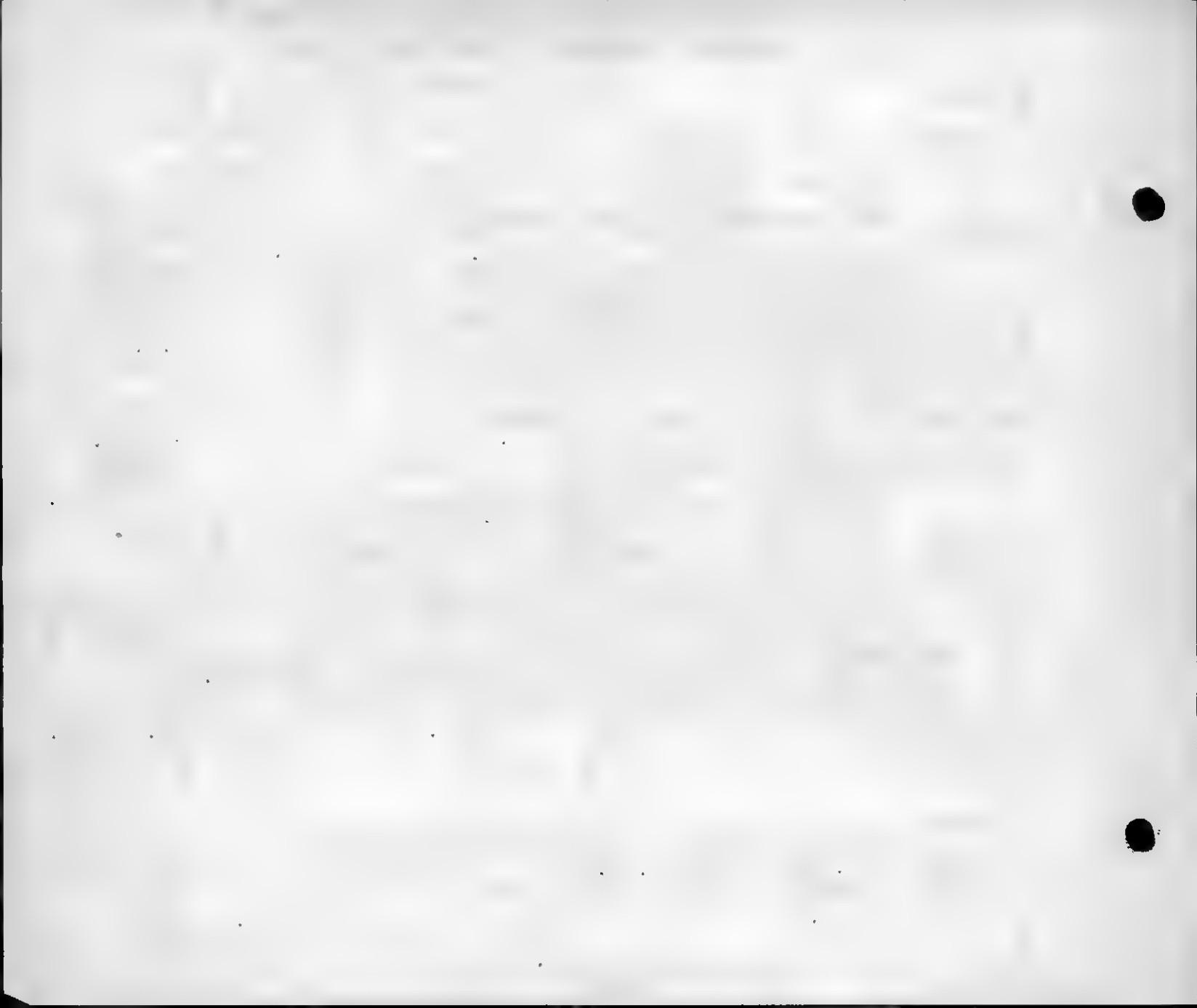
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 00260

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>		c. LENGTH OF STAY IN 1b <b>crossing road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hanover Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upperco</b>	
3. NAME OF DECEASED (Type or print) <b>William Donald Curtis Sr.</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>3,</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1914</b>
9. AGE (in years from birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Forman in Stone Quarry</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
10c. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Thomas J. Curtis</b>		14. MOTHER'S MAIDEN NAME <b>Charlotte B. Baseman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-07-8776</b>	
17. INFORMANT Address <b>Mrs. Margaret V. Curtis, Upperco, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>			
DUE TO <b>812X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____			
DUE TO <b>4" Laceration Rt. Occipital Area</b> (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)			
none			
19. WAS AUTOPSY PERFORMED? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PR. MARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased was crossing road &amp; was struck by automobile.</b>		20c. TIME OF INJURY Month, Day, Year <b>Hour 11:30 p.m. 1-3-60</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hanover Rd.</b>	
20f. (City or town) <b>Upperco</b>		(County) <b>Balto.</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>D. D. Caples</b>		DATE SIGNED <b>1-5-59</b>	
EXAMINER'S NAME (Type) <b>D. D. Caples, M. D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 6, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Pleasant Grove</b>		22d. LOCATION (City, town, or county) <b>Boring, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Clyde S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0287

## CERTIFICATE OF DEATH

Reg. Dist. No.

00261

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
BALTIMORE MARYLAND		MARYLAND BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
RURAL WOODLAWN	12 YEARS	RURAL WOODLAWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
2126 SOUTHLAND Rd	2126 SOUTHLAND Rd.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle ANTHONY	Last CUSIMANO
4. DATE OF DEATH	Month 7	Day 3	Year 1960
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 7 1907
9. AGE (In years last birthday)	IF UNDER 1 YEAR	10. IF UNDER 24 HRS	
52 yrs.	Months	Days	
11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
MARYLAND	U.S.A.		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
ANTHONY CUSIMANO	CAPITOLA WOODEN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
	1100 WHT 1945	WIFE MRS. ROSE CUSIMANO	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
CORONARY THROMBOSIS			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)			
DUE TO			
(c)			
11 54 YEARS AGO.			
INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 10/12 1954 to 11/3 1960 that I last saw the deceased alive on _____ 9/22/53 1959, and that death occurred at 2:05PM, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE Edwin L. Pierpont	DATE SIGN 11/3/60		
PHYSICIAN'S NAME (Type) EDWIN L. PIERPONT, MD	M.D. 8204 LIBERTY RD, BALTIMORE, MD 11/3/60		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-7-60	22c. NAME OF CEMETERY OR CREMATORIAL New Cathedral Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Ar Macost	ADDRESS 4600 Liberty Hghts	24a. REC'D BY REGISTRAR JAN 4 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
VS A15 (4) 15M 9/55			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0288

## CERTIFICATE OF DEATH

Reg. Dist. No.

00262

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Howard</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>11 Pine Drive Allview</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Shady Nook Nursing Home</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>HELEN (HELEN) BARNETT DALTON</b>		First	Middle	Last	4. DATE OF DEATH <b>January 8</b>	Month	Day	Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 4, 1897</b>	9. AGE (In years lost birthday) <b>62</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Alfred W. Barnett</b>				14. MOTHER'S MAIDEN NAME <b>Eva Harvey</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Sandra B. Denny, Ellicott City, Md</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATION</b>						INTERVAL BETWEEN ONSET AND DEATH			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>GENERAL</b> (c) <b>CARDIAC</b>						2 yrs.			
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (c) <b>CARDIAC</b>						5 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <b>1-22</b> , 19 <b>59</b> , to <b>1-8</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-5</b> , 19 <b>60</b> , and that death occurred at <b>254</b> M, from the causes and on the date stated above.								ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>P. V. Thorpe</i>		M.D.		Ellicott City, Md.		DATE SIGNED <b>1-8-60</b>			
PHYSICIAN'S NAME (Type) <b>P. V. Thorpe M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-11-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Meadowridge Memorial</b>		22d. LOCATION (City, town, or county) <b>Elkridge, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Hines</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be signed by the hospital or attending physician. To FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00263

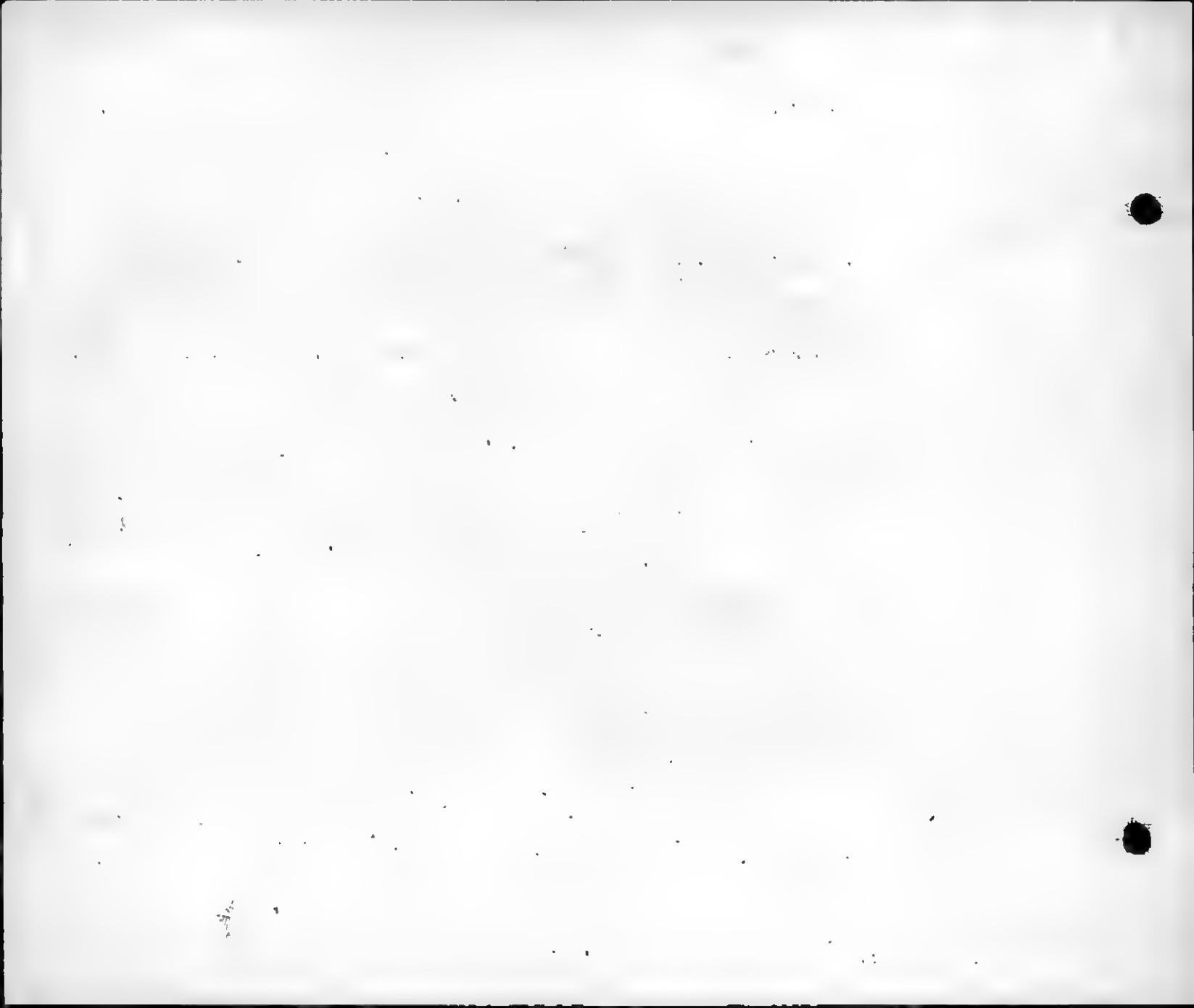
## 023i CERTIFICATE OF DEATH

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE	
Baltimore MARYLAND		Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Carney			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
9812 Harford Road		d. STREET ADDRESS 9812 Harford Road	
3. NAME OF DECEASED (Type or print)		First	Middle
Mr. John Lyon Deitz			Last
4. DATE OF DEATH		Month	Day
		January	20
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 17, 1873
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Retired Gardener		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		Baltimore Co. Maryland USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
?		Ella Levering	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. INFORMANT Address	
Yes, no, or unknown		Mrs. Lena Deitz, 9812 Harford Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
Myocardial degeneration   2 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
Atherosclerosis, Generalized   10+ yrs			
(c) DUE TO			
Generalized debilitation			
Parkinsonism.			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL, (Specify)		22b. DATE THEREOF	
Burial		1/23/60	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Lorraine Park		Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR DATE	
Leonard J. Ruck 5305 Harford Road #14		JAN 22 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Arthur S. Kram			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reprinted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



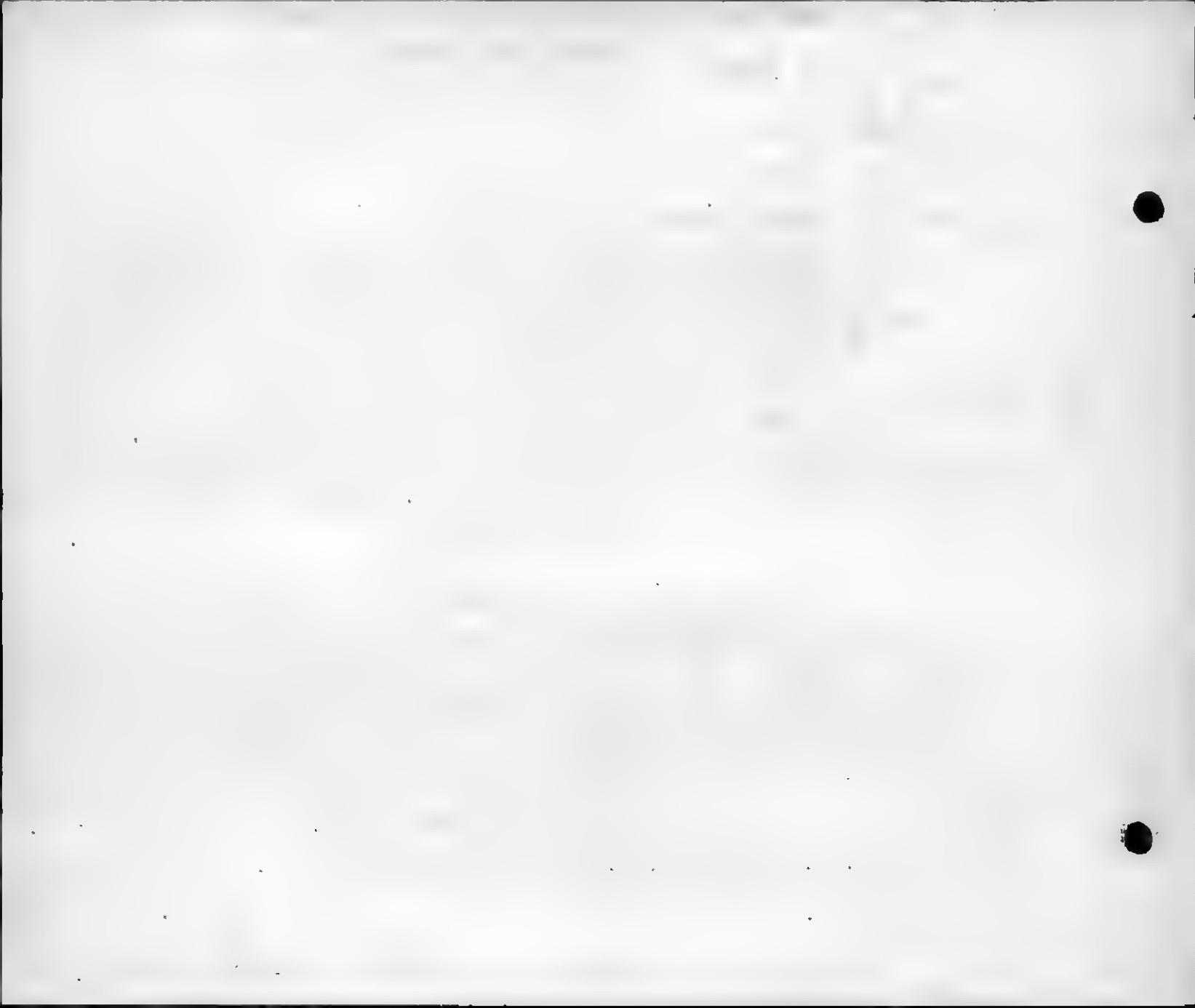
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00264

## CERTIFICATE OF DEATH

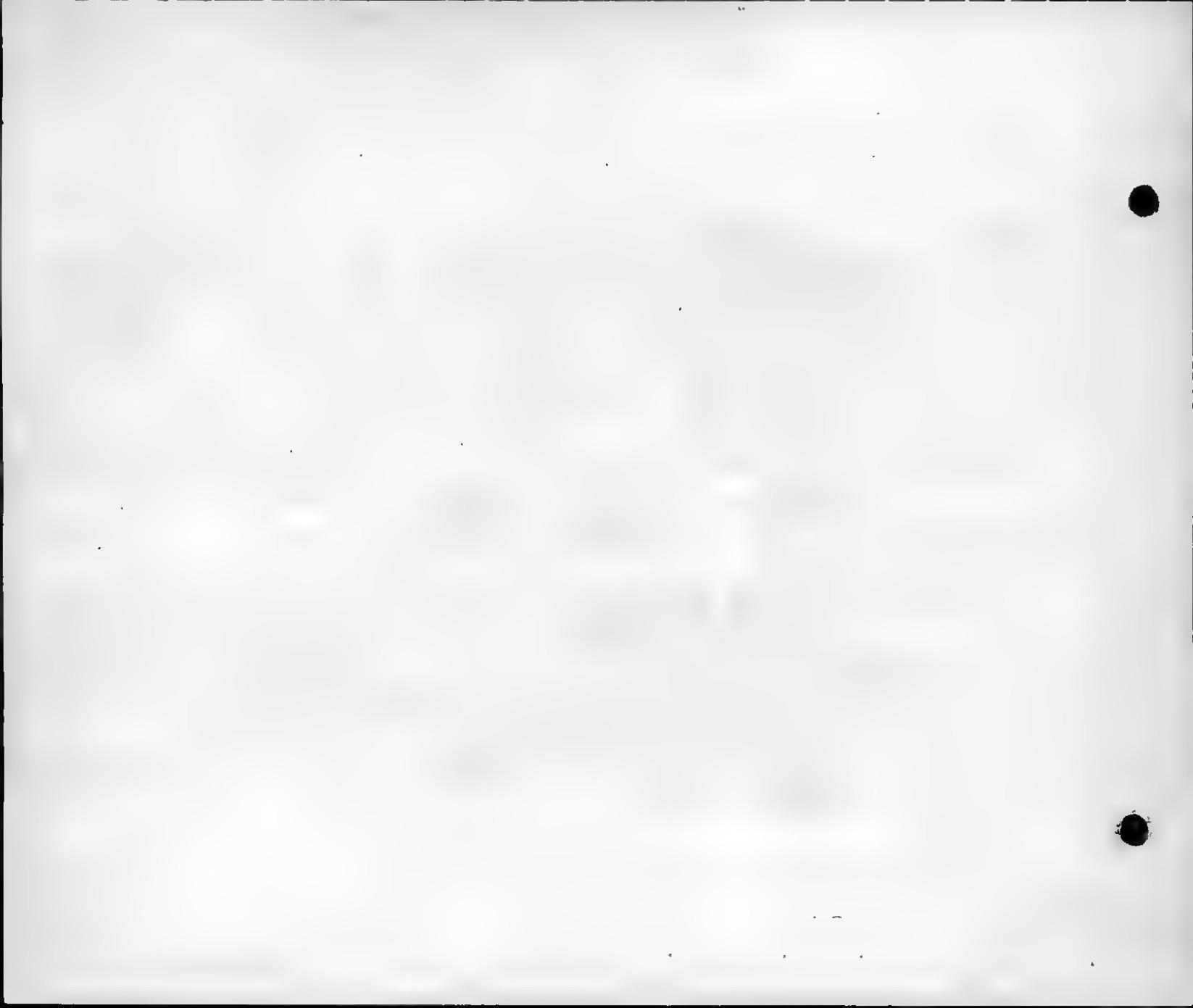
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown	c. LENGTH OF STAY IN lb 50yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Reisterstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 42 Bond Ave.	d. STREET ADDRESS 42 Bond Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Joshua Middle L. Dett	Last	4. DATE OF DEATH Jan. 17, 1960	Month 1960 Day 17 Year 19
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 9, 1888
9. AGE (In years last birthday) 71 yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Issac Dett		14. MOTHER'S MAIDEN NAME Martha Mack	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 218-34-2168	
17. INFORMANT Annie D. Madden, Reisterstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes, Urinary Incontinence		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. none 19 p. m.		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	
20e. (City or town) none		(County) none	
(State) none			
21. I certify that I attended the deceased from 2-25-38, 19, to 1-17-60, 19, that I last saw the deceased alive on 1-15-60, 19, and that death occurred at 3 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 6 Hanover Rd.			
DATE SIGNED 1-18-60			
ACTUAL SIGNATURE <i>D. D. Caples, M.D.</i>		PHYSICIAN'S NAME (Type) D. D. Caples, M. D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 20/60	
22c. NAME OF CEMETERY OR CREMATORIUM St. Lukes		22d. LOCATION (City, town, or county) Reisterstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE Jan 21 '60	
		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knapp</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be read by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
0289 CERTIFICATE OF DEATH				00265							
<b>1. PLACE OF DEATH</b> a. COUNTY <b>BALTIMORE</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYNSVILLE</b> c. LENGTH OF STAY IN 1b <b>6 yrs. &amp; 11 months</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>				<b>2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission)</b> a. STATE <b>MARYLAND</b> b. COUNTY <b>MARYLAND</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b> d. STREET ADDRESS <b>10310 DETRICK AVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED (Type or print)</b> <b>HATTIE</b>		First	Middle	Last	<b>4. DATE OF DEATH</b> <b>JAN 4 1960</b>		Month	Day	Year		
<b>5. SEX</b> <b>F</b>		<b>6. COLOR OR RACE</b> <b>W</b>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9-18-1869</b>		<b>9. AGE (In years from birthday)</b> <b>90</b>		<b>IF UNDER 1 YEAR</b> Months <b>0</b> Days <b>0</b>	<b>IF UNDER 24 HRS</b> Hours <b>0</b> Min <b>0</b>
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>HOUSEWIFE</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>CANADA</b>				<b>11. BIRTHPLACE (State or foreign country)</b> <b>U.S.</b>			
<b>13. FATHER'S NAME</b> <b>RICHARD KELLOGG</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>MATILDA LOREE</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>NONE</b>				<b>17. INFORMANT</b> <b>Frank L. Smith Jr.</b>			
								<b>Address</b> <b>Cockeysville, Md.</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>Arterios Oclerotic Cardios</b> <b>Vascular Disease</b> <b>6 years</b>							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterios Oclerotic Cardios</b> <b>Vascular Disease</b>				DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (If either, notify medical examiner)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <b>19</b> p. m.				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>2-6-1953</b>		<b>(County)</b> <b>1-4-1960</b>	
										<b>(State)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1-4 1960</b> , and that death occurred at <b>2:55P</b> , from the causes and on the date stated above											
<b>22a. SIGNATURE</b> <b>Walter T. Kees</b>				<b>M.D.</b> <b>ATTENDING PHYS.</b> <input type="checkbox"/>		<b>MED. DIRECTOR</b> <input checked="" type="checkbox"/>		<b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>1/4/60</b>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>WALTER T. KEEPS</b>				<b>22d. ADDRESS</b> <b>Cockeysville, Md.</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>23b. DATE THEREOF</b> <b>1-6-60</b>		<b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Rockville Union Cemetery</b>				<b>23d. LOCATION (City, town, or county)</b> <b>Kensington, Md.</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook, Inc., 1217 St. Paul Street</b>				<b>ADDRESS</b> <b></b>		<b>25a. REC'D BY REGISTRAR</b> <b>JAN 6 '60</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kraus</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

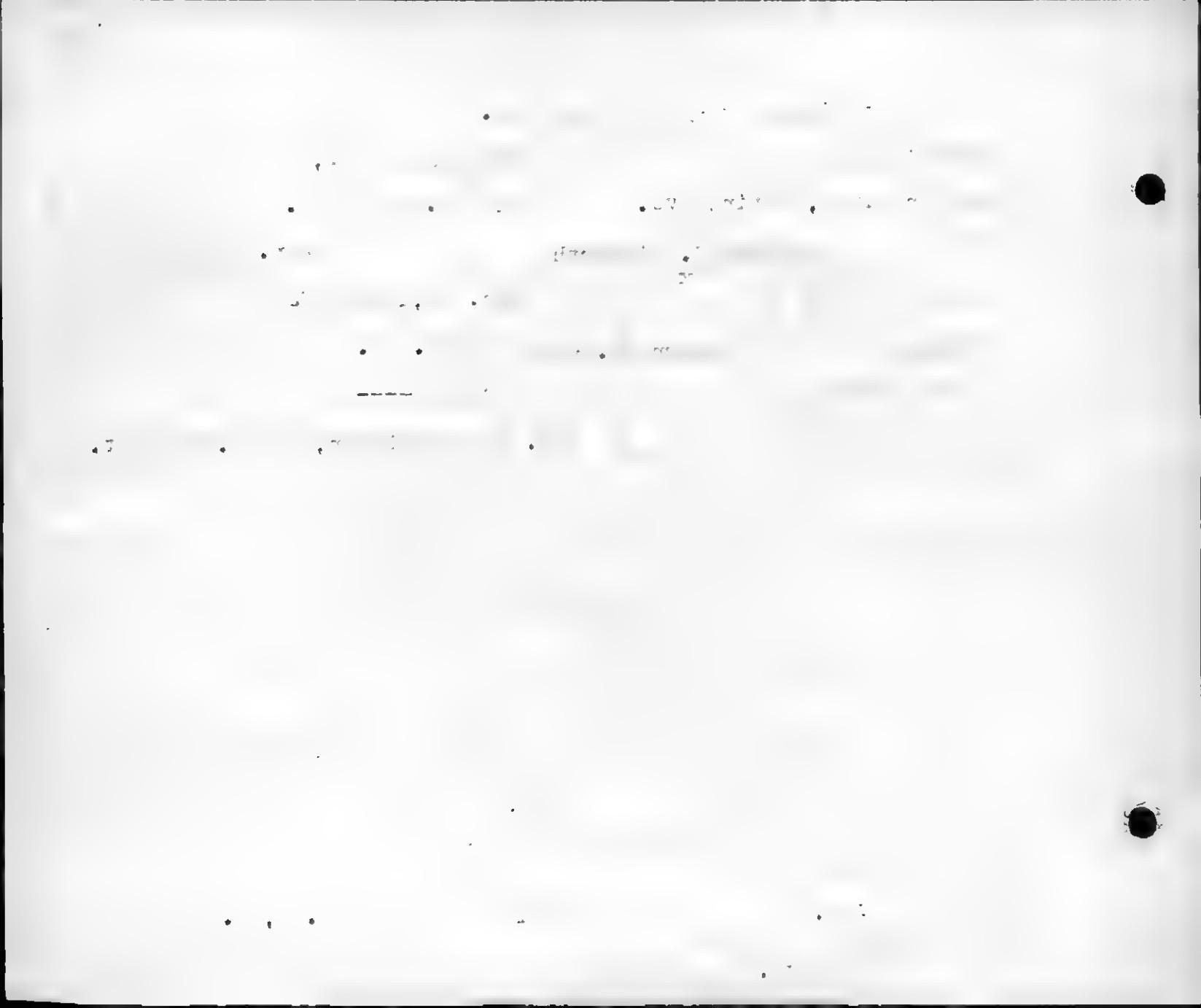
0290

## CERTIFICATE OF DEATH

Reg. Dist. No.

00266

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>House in Pines, Fusting Ave.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 29. 2 Yu / 4	
3. NAME OF DECEASED (Type or print) <b>William O. Dilworth</b>		4. DATE OF DEATH <b>Jan. 20/60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 12, 1887</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Western Md. Dairy</b>	
10c. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		11. AGE (In years (last birthday) 73 yrs	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Oliver Dilworth</b>	
14. MOTHER'S MAIDEN NAME <b>Caroline----</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		INFORMANT <b>Mrs. Mary Atkinson, 817 Mt. Holly St.</b>	
17. ADDRESS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATTERIOSCLEROTIC CARDIOVASCULAR</b> 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>DISEASE</b> (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20d. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20e. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20f. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.		20g. (City or town) (County) (State) 3629 Edmondson Ave. 1/21/60	
21. I certify that I attended the deceased from _____, 1950, to _____, 1960, that I last saw the deceased alive on _____, 1960, and that death occurred at _____, 1960, from the causes and on the date stated above. ACTUAL SIGNATURE: <b>Thos E Roach</b> PHYSICIAN'S NAME (Type): <b>Thos E Roach</b>		ADDRESS (Street, city or town, state) Baltimore - 29 - Md DATE SIGNED 1/21/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 23/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>New Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. 29. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Nitzke Funeral Directors</b> 4101 Edmondson Ave.		24a. REC'D BY REGISTRAR DATE JAN 22 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Colleen S. Tracy</b>	



X

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**0291 CERTIFICATE OF DEATH**

00267

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b COCKEYSVILLE 6 MONTHS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		MASONIC HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1725 SELMA AVE					
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
FLORENCE			C	DISNEY	JAN	5	1960.				
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS				
FE		W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	AUG 26 1879	80 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
HOUSEWIFE				MARYLAND		U.S.					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address <i>Frank L. Smith Jr - Cockeysville, Md.</i>							
WILLIAM UPTON		MARY ANN ROGERS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service)		16. SOCIAL SECURITY NO		17. INFORMANT							
NO		NONE		<i>Frank L. Smith Jr - Cockeysville, Md.</i>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Vascular Accident		INTERVAL BETWEEN ONSET AND DEATH <i>4 months.</i>							
445X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		DUE TO (b)	Hypertensive Arterio - Sclerotic Cardio Vascular disease.								
DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from 7-14 1959 to 1-4 1960 that (I) (we) last saw the deceased alive on 1-4 1960, and that death occurred 2:20 P.M. from the causes and on the date stated above											
22a. SIGNATURE <i>Walter T. Kees</i>		M.D.		ATTENDING PHYS <input type="checkbox"/>	MED DIRECTOR <input checked="" type="checkbox"/>	STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <i>1/5/60.</i>				
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		<i>Cockeysville, Md.</i>							
WALTER T. KEEPS											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 1-8-60		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery		23d. LOCATION (City, town, or county) Baltimore		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE William Cook, Inc., 1217 St. Paul Street		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 7 '60		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

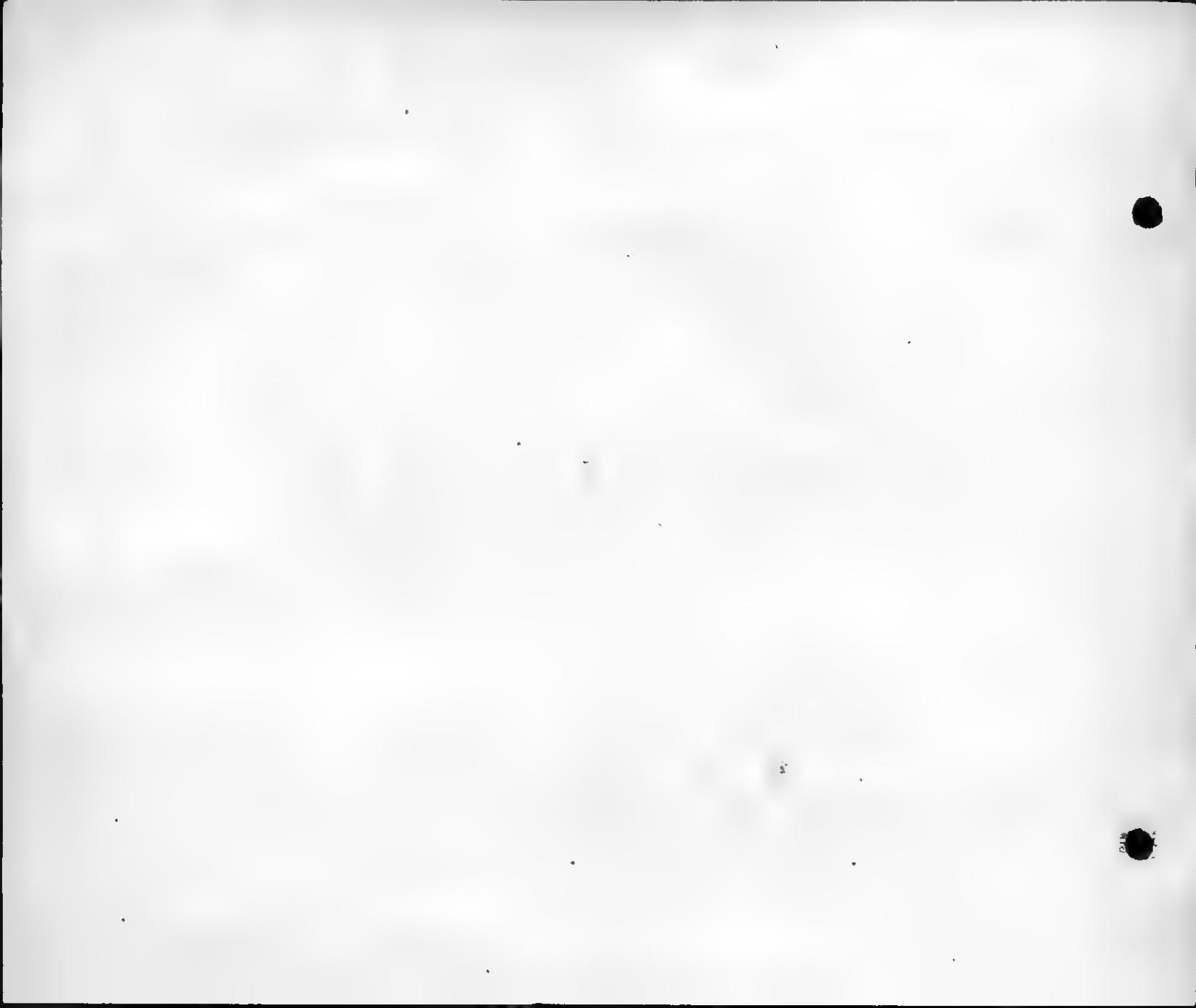
Item 14 file #2,52-1-60 et  
0237

## CERTIFICATE OF DEATH

Reg. Dist. No.

00268

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3017 Fourth Ave		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Carney	
3. NAME OF DECEASED (Type or print) Sarah		First Elizabeth	Middle Dunaway
4. DATE OF DEATH Jan 25,		Month Jan	Day 25
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH Feb. 12, 1881		9. AGE (in years last birthday) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY at home	11. BIRTHPLACE (State or foreign country) Penn.
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Hazel		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO none	
17. INFORMANT Mrs. John Kramer		Address 3017 4 th. Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 45-2-1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) DUE TO (c) DUE TO and Contributive heart failure } PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) (d) Generalized Atherosclerosis (e) Hyperthyroidism			
INTERVAL BETWEEN ONSET AND DEATH 1/2 yrs.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 19th Jan 1960
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, 19_____. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Dr. Frank T. Kasik, Jr. M.D.			
DATE SIGNED 4/25/60			
PHYSICIAN'S NAME (Type) Dr. Frank T. Kasik, Jr.		9005 Harford Road Baltimore Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/28/60	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park
22d. LOCATION (City, town, or county) Baltimore		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Chas. F. Evans & Son 882 Harford Rd.		24a. REC'D BY REGISTRAR JAN 27 '60	24b. REGISTRAR'S SIGNATURE Charles S. Evans



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

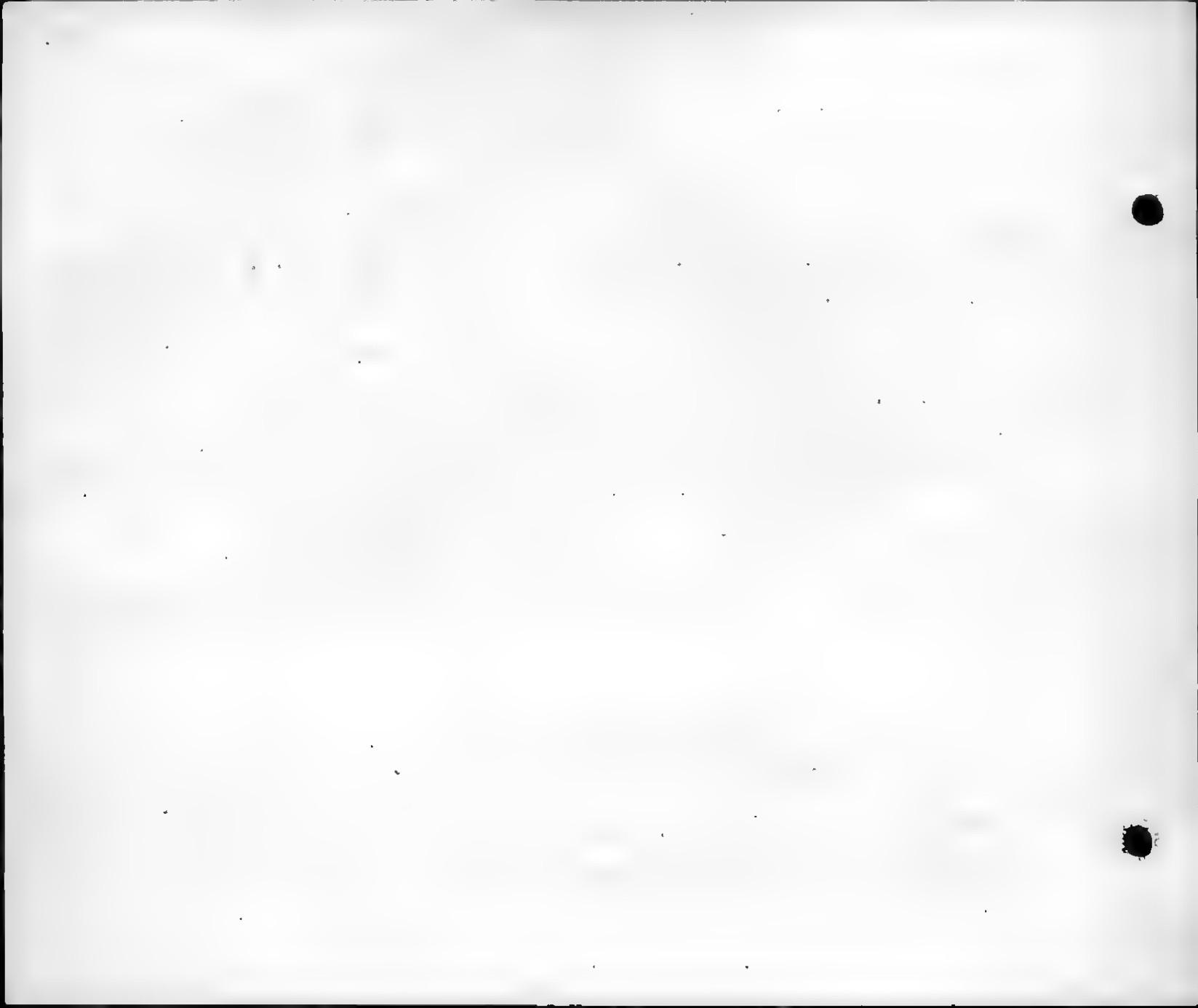
0292

## CERTIFICATE OF DEATH

Reg. Dist. No.

00269

1 M X I		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coventry	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Coventry X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1811 Rushley Road		d. STREET ADDRESS 1811 Rushley Road #34	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELIZABETH M. EHMAN	Middle	Last
4. DATE OF DEATH	Month Jan.	Day 21	Year 19 60
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 3, 1902
9. AGE (In years lost birthday) 57 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Clarence T. McAfee	14. MOTHER'S MAIDEN NAME Sarah Edel		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. Yes	INFORMANT Mr. Rae M. Ehman-1914 Edgewood Road #4	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO ASCVD (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH Summer 7 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10/12, 1959, to 1/21, 1960, that I last saw the deceased alive on 1/21, 1960, and that death occurred at 7:30 PM, from the causes and on the date stated above ACTUAL SIGNATURE Kathy J. King		ADDRESS (Street, city or town, state) M.D. 1102 E. Joppa Rd #4 Baltimore, Maryland DATE SIGNED 1/23/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/25/60	22c. NAME OF CEMETERY OR CREMATORIUM Parkwood Cemetery
22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Tucker, Esq. P.O. Box 17, Md.		24a. REC'D BY REGISTRAR DATE JAN 25 '60	24b. REGISTRAR'S SIGNATURE John J. Tucker



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0293 CERTIFICATE OF DEATH

Reg. Dist. No.

00270

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>4 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Stella Maris Hospice</b>				d. STREET ADDRESS <b>2008 McElderry Street</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Ada</b>		First	Middle	Last	4. DATE OF DEATH <b>Enright</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/8/1888</b>		9. AGE (In years last birthday) <b>71</b> yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bank Teller</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>			
13. FATHER'S NAME <b>Thomas Ruckle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ward</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO <b>226-24-8593</b>		17. INFORMANT		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>44</b> DUE TO <b>High Cardiac Compensation</b> (01/20/60 day of death) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension Cardio Keria</b> (c) <b>Angular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>4/8 hrs.</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>1100, 1960</b>		(County) <b>BALTIMORE</b> (State) <b>M.D.</b>	
21. I certify that I attended the deceased from <b>1/20/60</b> to <b>1/21/60</b> that I last saw the deceased alive on <b>1/20/60</b> , and that death occurred at <b>12:00 PM</b> , from the causes and on the date stated above.							ADDRESS (Street, city or town, state) <b>1501 York Rd</b>	DATE SIGNED <b>1/21/60</b>	
ACTUAL SIGNATURE <b>Charles F. O'Donnell - M.D.</b>									
PHYSICIAN'S NAME (Type)									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>1-23-60</b>		22b. DATE THEREOF <b>New Cathedral</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BALTIMORE M.D.</b>		22d. LOCATION (City, town, or county)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Buck 5305 Hayford</b>		ADDRESS <b>JAN 26 '60</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>		24b. REGISTRAR'S SIGNATURE			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0294

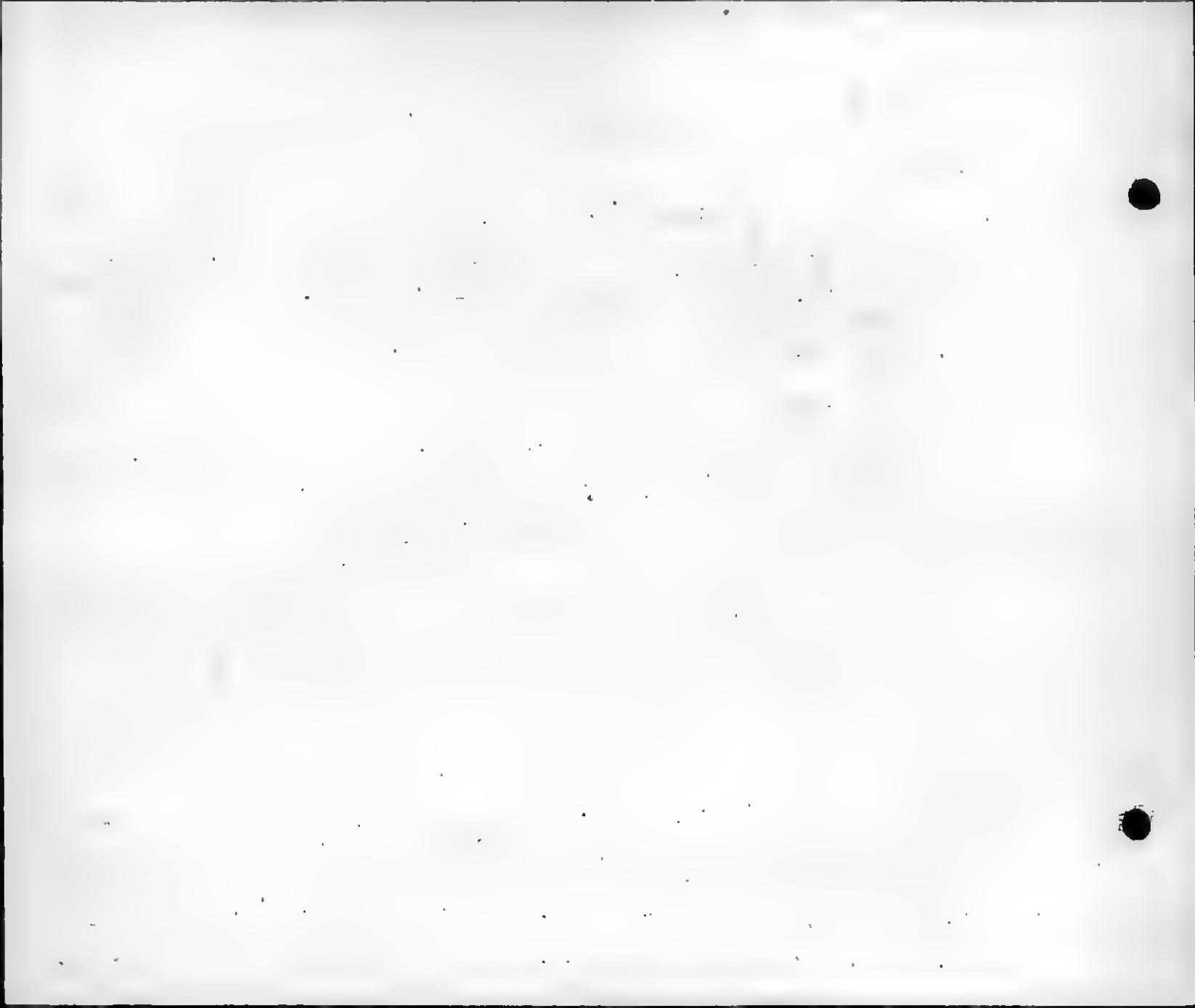
## CERTIFICATE OF DEATH

Reg. Dist. No.

06271

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Parkville</i>	c. LENGTH OF STAY IN 1b <i>Parkville</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <i>7508 Old Harford Rd.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7508 Old Harford Rd.</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Robert</i>	First	Middle	Last <i>Everett</i>
4. DATE OF DEATH <i>Jan. 23 1960</i>	Month	Day	Year
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9-28-1884</i>
9. AGE (In years last birthday) <i>75 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Carpenter</i>	10b. KIND OF BUSINESS OR INDUSTRY	11 BIRTHPLACE (State or foreign country) <i>Penna.</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>John Everett</i>	14. MOTHER'S MAIDEN NAME <i>Cynthia</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO.	INFORMANT <i>Gussie V. Everett</i>	Address <i>same</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes Mellitus &amp; Diabetes</i> 260x DUE TO <i>Neuropathy + Coma</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>10-30 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>1</i>	
20c. TIME OF INJURY Month, Day, Year Hour o m <i>19</i> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street office bldg., etc.) <i>1100 Lm</i>
20f. (City or town) <i>1100 Lm</i>		(County)	(State)
21. I certify that I attended the deceased from <i>Jan 15 1957</i> to <i>Jan 23 1960</i> that I last saw the deceased alive on <i>Jan 23 1960</i> , and that death occurred at <i>1100 Lm</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Donald W. Murphy</i>		ADDRESS (Street, city or town, state) <i>M.D. 3029 EVERGREEN AV BALTIMORE 14 MD</i>	
DATE SIGNED <i>1/25/60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1-27-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Fork Meth. Cemetery</i>
22d. LOCATION (City, town, or county) <i>Fork, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd.</i>		24a. REC'D BY REGISTRAR <i>JAN 26 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>



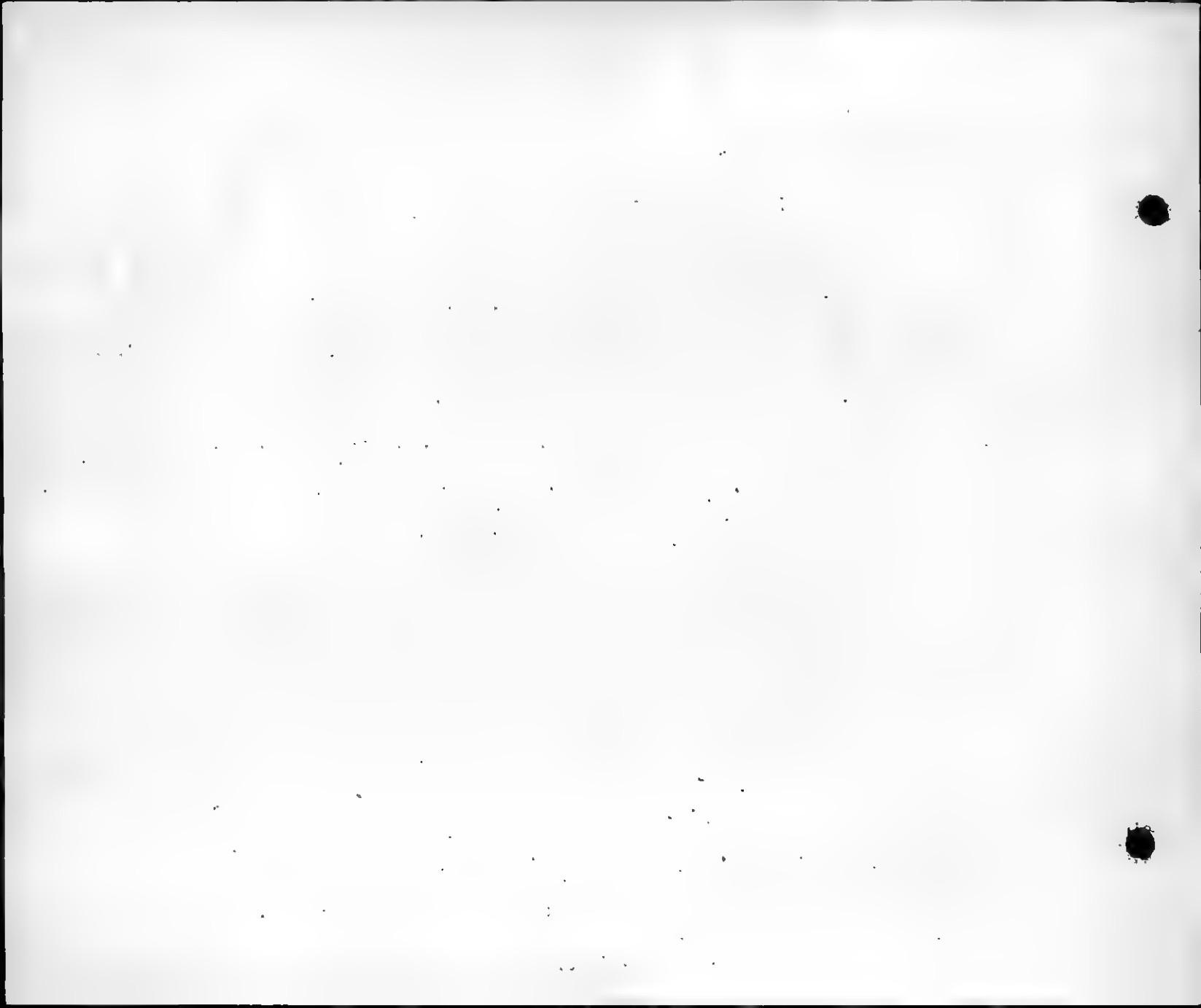
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0295 CERTIFICATE OF DEATH

Reg. Dist. No. 011272

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Catoonsville	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Arbutus		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Ridgeway Manor Nursing Home	d. STREET ADDRESS  Sulphur Spring Road	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)  GLADYS	First  GLADYS	Middle  	Last  FEAR	
4. DATE OF DEATH  January 28	Month  January	Day  28	Year  1960	
5. SEX  Female	6. COLOR OR RACE  White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH  Dec. 29, 1907	
			9. AGE (In years last birthday) 52 yrs.	
10a. US-JAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Housewife		10b. KIND OF BUSINESS OR INDUSTRY  11. BIRTHPLACE (State or foreign country)  Baltimore, Maryland		
12. CITIZEN OF WHAT COUNTRY?  U.S.A.				
13. FATHER'S NAME  Frank B. Myers		14. MOTHER'S MAIDEN NAME  Sadie R. Snouffer		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  No	16. SOCIAL SECURITY NO  None	INFORMANT  Mr. George R. Myers-1424 W. 37th Street	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)  422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  (b) DUE TO  Artic Cardio-vasc. Dis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks -		
(c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  Baltimore, Maryland (County)  	(State)
21. I certify that I attended the deceased from <u>1/28</u> , 19 <u>60</u> , to <u>1/28</u> , 19 <u>60</u> , and that I last saw the deceased alive on <u>1/28</u> , 19 <u>60</u> , and that death occurred at <u>429 S Chester St</u> , M.D., from the causes and on the date stated above.		ADDRESS (Street, city or town, state)		DATE SIGNED
ACTUAL SIGNATURE  Theodore T. Nezvuk M.D.				
PHYSICIAN'S NAME (Type)  Theodore T. Nezvuk M.D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/1/60	22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland	(State)
23. FUNERAL DIRECTOR'S SIGNATURE  John J. Nezvuk, Esq.		ADDRESS  Baltimore - 17, Md.	24a. REC'D BY REGISTRAR Date FEB 2 60	24b. REGISTRAR'S SIGNATURE  Arthur S. Nezvuk

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00273

## 0296 CERTIFICATE OF DEATH

Reg. Dist. No.

32

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson</b>		c. LENGTH OF STAY IN 1b <b>24 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havre de Grace</b>	
3. NAME OF DECEASED (Type or print) <b>John Edward Fell</b>		d. STREET ADDRESS <b>Robin Hood Rd</b>	
		4. DATE OF DEATH <b>1 11 1960</b>	Month Day Year
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/19/1900</b>
9. AGE (In years from birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Manager</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Resturant</b>	
11. BIRTHPLACE (State or foreign country) <b>Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry Fell</b>		14. MOTHER'S MAIDEN NAME <b>Mary Maguire</b>	
15. WAS DECEASED EVER IN THE U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-34-3245</b>	
17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the Lung</b> DUE TO <b>16 JX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <b>7 mo</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____ 12/18, 1959 to 1/11, 1960, that I last saw the deceased alive on _____ 1/11, 1960, and that death occurred at 2A, M, from the causes and on the date stated above. ACTUAL SIGNATURE M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Mt. Wilson, Maryland</b>	
PHYSICIAN'S NAME (Type) <b>William Newcomer, M.D.</b>		Superintendent	
22a. BURIAL/CREMATION REMOVAL (Specify) <b>1/14/60</b>	22b. DATE THEREOF <b>1/14/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Angel Dell</b>	22d. LOCATION (City, town, or county) <b>Havre de Grace Md.</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



1X

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same date, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00274

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MIDDLE RIVER MARYLAND		c. STATE MARYLAND b. COUNTY BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		3 YRS		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
2216 FIRETHORN RD #20				f. STREET ADDRESS MIDDLE RIVER	
3. NAME OF DECEASED (Type or print)		First PHILIP	Middle M.	4. DATE OF DEATH	Month JAN Day 21 Year 1960
3. SEX MALE		6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 15, 1923	9. AGE (In years last birthday) 36 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY AUTO REPAIR OWNER-GARAGE		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA U.S.A.	
13. FATHER'S NAME JOHN G FOLEY		14. MOTHER'S MAIDEN NAME LOUIE COURAD		12. CITIZEN OF WHAT COUNTRY? Address 2216 FIRETHORN RD #20	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 113-30-142		17. INFORMANT MRS HELEN A FOLEY, INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO (b)		BULLET Wound (8mm) Thru Head	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		DUE TO (c)		startly under chin & exiting thru top of head	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Indicate nature of injury in Part I or Part II of item 18.) SHOT Self Thru Chin & head		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year 105 1-21 1960		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home 20f. (City or town) Middle River-Baltimore Md (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M. B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/22/60	
EXAMINER'S NAME (Type) M. B. Davis M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN 23, 1960		22c. NAME OF CEMETERY OR CREMATORIAL BELAIR MEMORIAL	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph Funeral Home 74 mi Belair Rd		ADDRESS		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
				24b. REGISTRAR'S SIGNATURE Charles S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

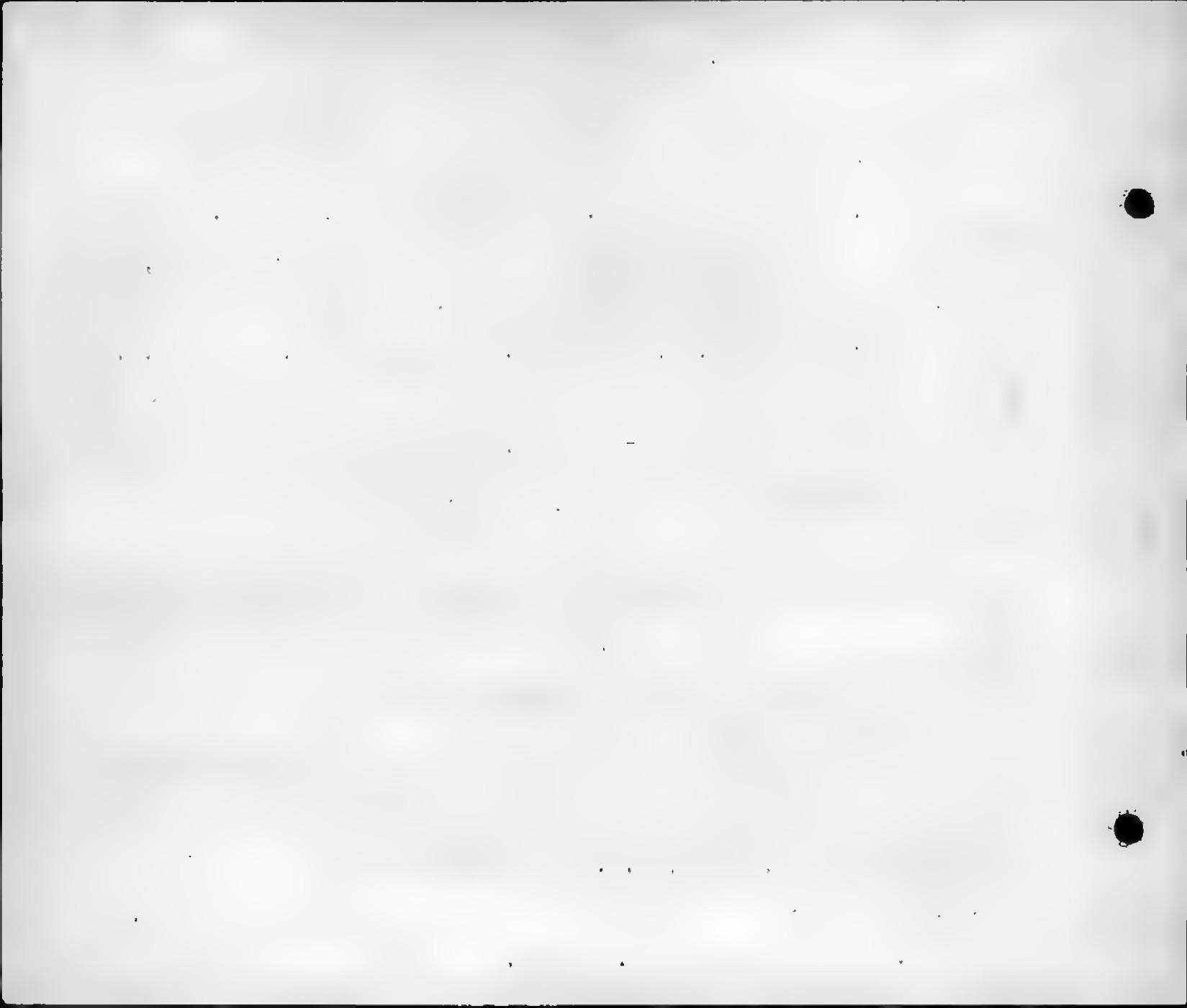
00275

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM2. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		d. STREET ADDRESS <b>2505 Mc Comas Ave.</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Residence, 2505 Mc Comas Ave.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>Carl</b>	Middle <b>George</b>	Lost <b>Foltz</b>	4. DATE OF DEATH <b>January 15, 1960</b>	Month <b>January</b>	Day <b>15</b>	Year <b>1960</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 17, 1907</b>	9. AGE (In years b. month b. day) <b>52 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>C. D. Walker Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		
13. FATHER'S NAME <b>Robert Foltz</b>				14. MOTHER'S MAIDEN NAME <b>Ida Roth</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tax no. or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Army WW II 212-00-7110</b>		17. INFORMANT Address <b>Mrs. Julia Foltz 2505 Mc Comas Ave. 22</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Coronary Occlusion</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b)</b>								
DUE TO <b>(c)</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Homicide</b>						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Eastern Blvd.</b>	(County) <b>Md.</b>	(State) <b>22. BURIAL, CREMATION, REMOVAL (Specify) Burial</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Melvin B. Davis, M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED <b>1/15/60</b>								
22b. DATE THEREOF <b>1-18-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) <b>Eastern Blvd. Md.</b>				
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda 7922 Wise Ave. 22, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>AN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0217 CERTIFICATE OF DEATH

00276

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rundale</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OR INSTITUTION —		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Herttrude Gale Francis</i>		First	Middle
		Last	
4. DATE OF DEATH Month Day Year <i>Jan. 28 1960</i>		Month	Day
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <i>Apr 28-1923</i>		9. AGE (In years less birthday) <i>36</i>	10. IF UNDER 1 YEAR Months Days Hours Min. <i>0 0 0 0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY —	11. BIRTHPLACE (State or foreign country) <i>Tong Branch W. Va.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		Address <i>7902 St. Brigid's Lane Dundalk</i>	
13. FATHER'S NAME <i>William Anderson Akers</i>		14. MOTHER'S MAIDEN NAME <i>Ela K. Payne</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>236-24-9860</i>	
17. INFORMANT <i>Earl Francis</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO <i>592X</i> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Chronic Glomerulonephritis</i> DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Diabetes Mellitus - Hypertensive Cardiovascular Disease</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>Jan. 28, 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Baltimore</i>	
21. I certify that I attended the deceased from <i>Nov. 20, 1958</i> , to <i>Jan. 28, 1960</i> , that I last saw the deceased alive on <i>Jan. 28, 1960</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above. ACTUAL SIGNATURE <i>Manuel P. de Leon</i>		ADDRESS (Street, city or town, state) <i>1840 Eastern Ave - Baltimore 24, Maryland</i>	
PHYSICIAN'S NAME (Type) <i>MANUEL P. DE LEON</i>		DATE SIGNED <i>Jan. 25, 1960</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 28, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Bell Air Memorial</i>		22d. LOCATION (City, town, or county) <i>Bell Air</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mark Archer, Benson Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Craig S. Trahan</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0298 CERTIFICATE OF DEATH

08277

Reg. Dist. No.

PLACE OF DEATH o COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o STATE Maryland b COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere	c. LENGTH OF STAY IN lb 45 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Res., 2517 S. Snyder Avenue	d. STREET ADDRESS 2517 S. Snyder Avenue		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Joseph Alexander Frazier	First Middle Last	4. DATE OF DEATH Jan. 31, 1960	Month Day Year		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1870	9. AGE (In years ' 109 yrs.)	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gen. Labor		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	11. BIRTHPLACE (State or foreign country) Pennsylvania	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes <input type="checkbox"/> or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT 214-10-0166 Mrs. Rose Marie Will	Address 2517 S. Snyder Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Congestive heart failure Pulmonary edema		INTERVAL BETWEEN ONSET AND DEATH 2 days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)				2 hours	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 914 D St	(County) (State)
21. I certify that I attended the deceased from Jan 5, 1958, to Jan 31, 1960, that I last saw the deceased alive on Jan 31, 1960, and that death occurred at 2 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE John V. Conway, M.D.					
PHYSICIAN'S NAME (Type) John V. Conway, M. D.		ADDRESS Balt. 19, Md.			
22a. BURIAL, CREMATION, REMOVALS (Specify) Burial		22b. DATE THEREOF 2-3-1960	22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn	22d. LOCATION (City, town, or county) Eastern Blvd.	(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda		ADDRESS 7922 Wise Ave. 22, Md.	24a. REC'D BY REGISTRAR DATE 1-1-60	24b. REGISTRAR'S SIGNATURE Arthur S. Koenig	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
 15M 10/57



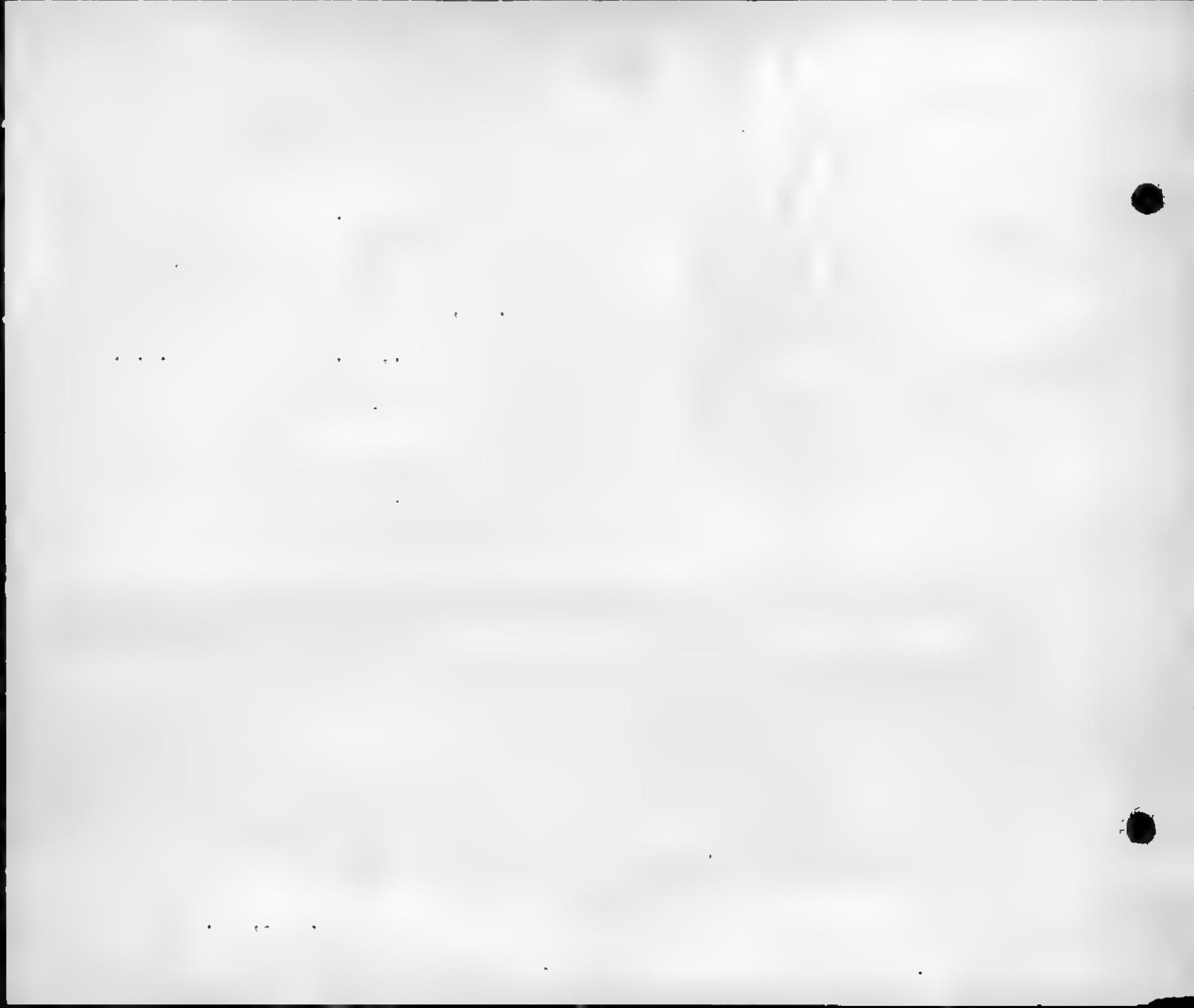
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00278

## 0299 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE  Maryland		b. COUNTY  Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Essex		c. LENGTH OF STAY IN lb  54		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Essex (21)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  Ivy Hall Convalescent home		d. STREET ADDRESS  147 Poplar Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)  Marie Helen Geckle		First	Middle	Last	4. DATE OF DEATH  January 20,	Month	Day	Year
5. SEX  Female	6. COLOR OR RACE  White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH  Oct. 31, 1911	9. AGE (In years last birthday)  48 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Clerk		10b. KIND OF BUSINESS OR INDUSTRY  County Government		11. BIRTHPLACE (State or foreign country)  Balto., Md.		12. CITIZEN OF WHAT COUNTRY?  U.S.A.		
13. FATHER'S NAME  Michael Schellenberger		14. MOTHER'S MAIDEN NAME  Catherine Langhirt						
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown)  No		16. SOCIAL SECURITY NO.  217-32-7724		17. INFORMANT  Dorothy Green		Address  Same		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  154 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO  (c) DUE TO		metastatic Carcinoma Carcinoma of uterus		INTERVAL BETWEEN ONSET AND DEATH  6 mo 4 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)  20f. (City or town)  Balto. Co., Md.		(County)		(State)
21. I certify that I attended the deceased from <u>Dec 26</u> , 19 <u>55</u> , to <u>Jan 20</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>60</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED <u>1/21/60</u>		
ACTUAL SIGNATURE  Joseph Miceli M.D.								
PHYSICIAN'S NAME (Type)  JOSEPH MICELI M.D. Baltimore 21 Lnd								
22a. BURIAL, CREMATION, REMOVAL (Specify)  Burial		22b. DATE THEREOF  1/23/60		22c. NAME OF CEMETERY OR CREMATORIAL  Sacred Heart of Jesus		22d. LOCATION (City, town, or county)  Balto. Co., Md.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE  James E. Bruzdinski		ADDRESS  1407 Eastern Ave.		24a. REC'D BY REGISTRAR  DATE Jan 25 '60		24b. REGISTRAR'S SIGNATURE  C. T. S. Kline		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0300

## CERTIFICATE OF DEATH

Reg. Dist. No.

00279

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be read by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, it may be filed in by him funeral director.  
 Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		b. COUNTY <b>A.A. Co.</b>	
c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glen Burnie</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor</b>		d. STREET ADDRESS <b>1145 McHenry Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Annie</b>	Middle <b>M.</b>	Last <b>Geldmacher</b>
4. DATE OF DEATH	Month <b>Jan.</b>	Day <b>24</b>	Year <b>1960</b>
S. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1892</b>
9. AGE (In years last birthday) <b>67 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Christian Fischer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine ---</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) <b>---</b>		16. SOCIAL SECURITY NO. <b>-----</b>	
17. INFORMANT <b>Mr. Ellwood Geldmacher, 1145 McHenry Dr.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral - muscular accident</i> DUE TO <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis - cerebral - vascular disease</i> DUE TO (c) <i>Dehydration &amp; edema - pulmonary</i></b>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ADDRESS (Street, city or town, state)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/1/60</b> , to <b>1/24/60</b> , that I last saw the deceased alive on <b>1/27/60</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>J. Schawdow</i>		ADDRESS (Street, city or town, state) <b>5803 Edgewater Rd.</b>	
PHYSICIAN'S NAME (Type) <b>J. Schawdow</b>		DATE SIGNED <b>1/26/60</b>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-27-60</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Foley Funeral Home - Catonsville, Md.</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 28 '60</b>	
ADDRESS <i>J. Schawdow</i>		24b. REGISTRAR'S SIGNATURE <i>John S. Pearce</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

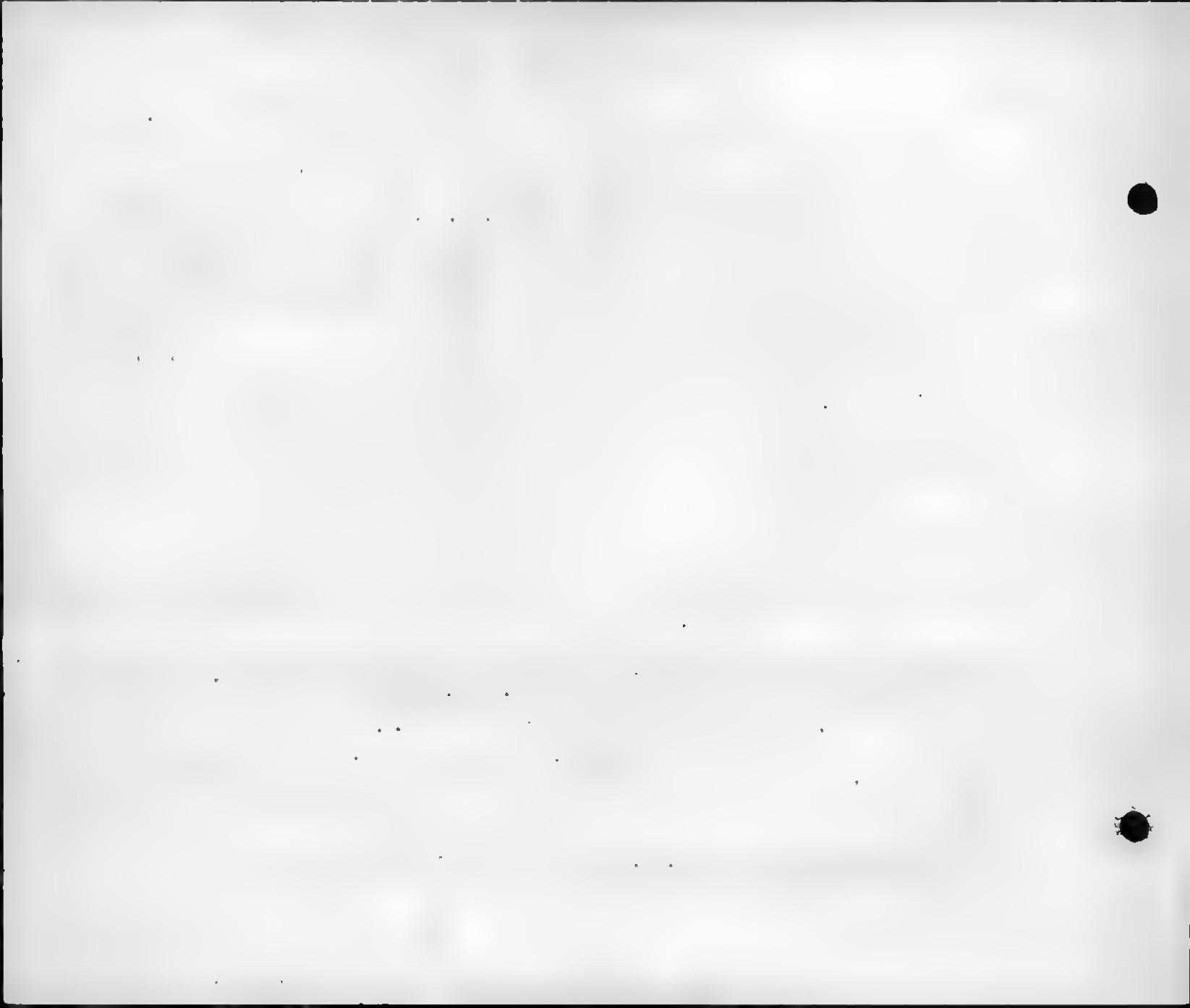
00280

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**0301 CERTIFICATE OF DEATH**

Reg. Dist. No. \_\_\_\_\_

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Balto.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth 14 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown, Md.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. STREET ADDRESS <b>R. F. D. #3 - Box 86</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ida</b>		First <b>Blanche</b>	Middle <b>Gemmecker</b>	Lost <b>January 4</b>	4. DATE OF DEATH <b>Month Day Year</b>	Month <b>January</b>	Day <b>4</b>	Year <b>1960</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 7, 1878</b>		9. AGE (In years from birthday) <b>71 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Hours <b>0</b>	12. IF UNDER 24 HRS Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Beautician</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Timothy W. Sewall</b>		14. MOTHER'S MAIDEN NAME <b>Mary Crowe</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>		Acute cardiac failure				INTERVAL BETWEEN ONSET AND DEATH		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		Arteriosclerotic cardiovascular disease						
DUE TO (c)		Generalized arteriosclerosis						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) <b>Diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>of rt. femur prior to adm. to Hospital in Nov., 1959-pinned at Union Memorial Hosp. Oct. 1959</b>		Pt. sustained frac.				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>Oct. 159</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, 120 ft. (City or town) factory, street, office bldg., etc.) <b>Reisterstown, Md.</b>		(County) <b>Baltimore County</b>		(State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____		Nov. 24, 1959, to Jan. 4, 1960		that I last saw the deceased alive on Jan. 4, 1960, and that death occurred at 1:55 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8728 Liberty Rd.</b>		DATE SIGNED <b>Arthur S. Kraus</b>
ACTUAL SIGNATURE <b>Stella Wachsler</b>		M.D.		SPRING GROVE STATE HOSPITAL 4-60				
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-7-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Long Biers</b>		ADDRESS <b>8728 Liberty Rd.</b>		24a. REC'D BY REGISTRAR <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0302 CERTIFICATE OF DEATH

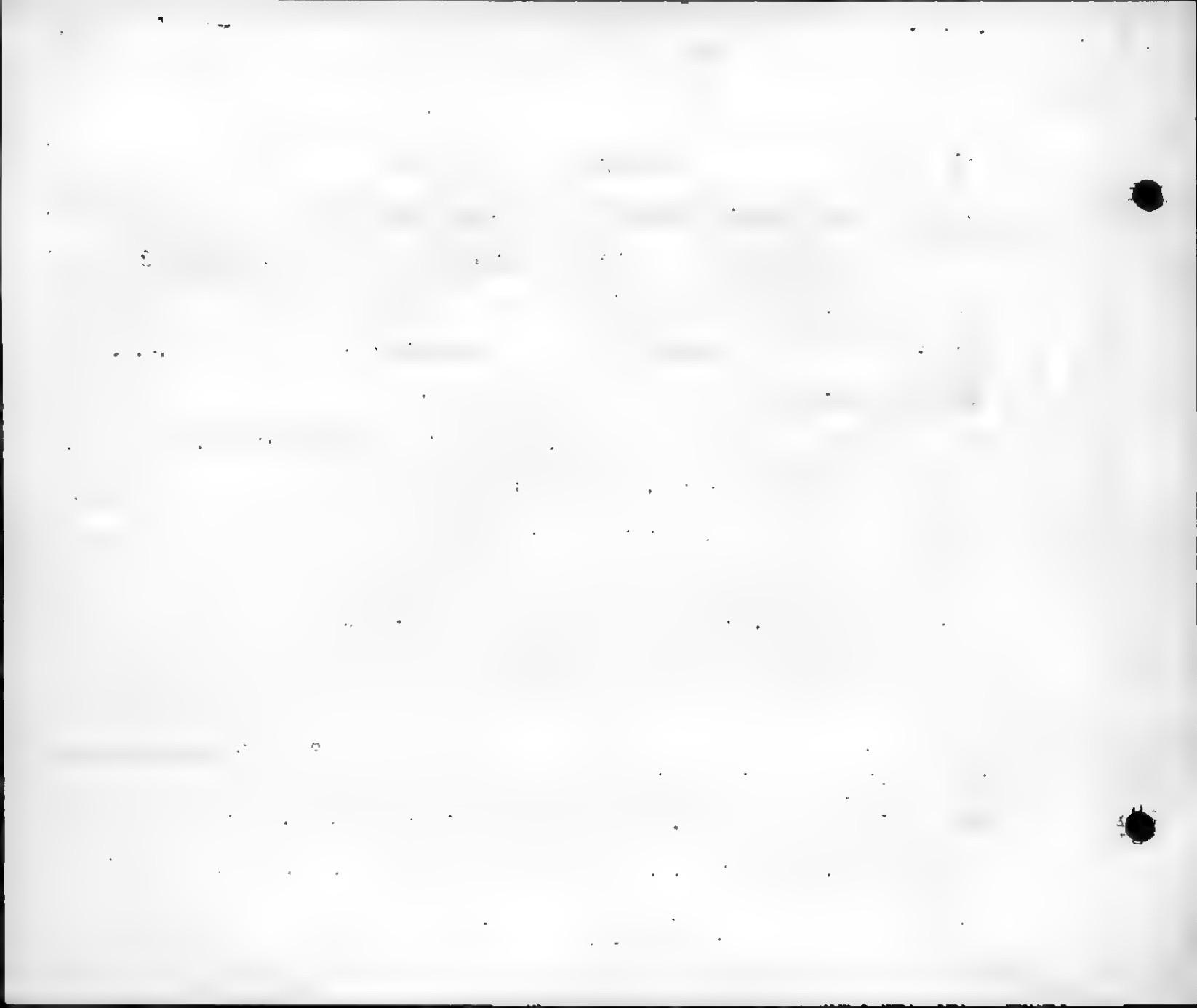
Reg. Dist. No.

00281

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>169 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>ISAAC</b>	Middle <b>—</b>	Last <b>GENSEMER</b>
S SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1888</b>
10a. US JAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
10c. FATHER'S NAME <b>GEORGE GENSEMER</b>		14. MOTHER'S MAIDEN NAME <b>LICCY ROTH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>YES</b>	16. SOCIAL SECURITY NO. <b>WW-1</b>	INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA, BILATERAL</b>			
491X			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>FIBROCASEOUS TUBERCULOSIS, RIGHT UPPER LOBE</b>			
(c) <b>EDEMA OF THE LUNGS, MODERATE</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 DAYS</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>HYPERTROPHY AND DILATATION OF THE LEFT CHAMBER OF HEART</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>COPX</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f (City or town)</b>		(County) (State)	
21. I certify that <b>VAH</b> attended the deceased from <b>July 17, 1959</b> to <b>January 3, 1960</b> , and that death occurred at <b>7:15 pm</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD., FT. HOWARD DIVISION</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>1/4/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-7-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Cook Blight Inc Baltimore 14 Md</b>		ADDRESS <b>6009 Harford Road</b>	
		24a. REC'D BY REGISTRAR <b>JAN 6 '60</b>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0303 CERTIFICATE OF DEATH

Reg. Dist. No.

01282

1. PLACE OF DEATH o COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE <b>ID</b>		b. COUNTY <b>BALTIMORE</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>		c LENGTH OF STAY IN 1b <b>2 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>PARKVILLE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2523 TAYLOR AVE</b>		d. STREET ADDRESS <b>2523 TAYLOR AVE</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>GEORGE R. GERWIG</b>		First	Middle	Last	4. DATE OF DEATH JAN 23 1960	Month	Day	Year
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>JULY 7, 1888</b>	9. AGE (In years lost birthday) <b>71 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Milk Dairy</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>		
13. FATHER'S NAME <b>Jacob F. Gerwig</b>		14. MOTHER'S MAIDEN NAME <b>Anne Lay</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>218-01-0792</b>		17. INFORMANT <b>AUGUSTA GERWIG 2523 TAYLOR AVE (1)</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>19</b>	Doy <b>19</b>	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>8400 North Larch Blv.</b>	(County) <b>Baltimore</b>	(State) <b>MD</b>
21. I certify that I attended the deceased from <b>12-25, 1959</b> to <b>1-23, 1960</b> , that I last saw the deceased alive on <b>1-23, 1960</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>8400 North Larch Blv. Baltimore MD</b> DATE SIGNED <b>1/25/60</b>								
ACTUAL SIGNATURE <i>Joseph F. Hilman, M.D.</i>	PHYSICIAN'S NAME (Type) <b>Joseph F. Hilman</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Jan 27, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>LOUDON PARK</b>	22d. LOCATION (City, town, or county) <b>BALTIMORE</b>		(State) <b>ID,</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Glenn J. Seitz 5209 York Rd.</i>		ADDRESS <b>12</b>	24a. REC'D BY REGISTRAR <b>JAN 26 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Charles E. Hayes</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00283

0304

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbons papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<u>BALTIMORE</u>		a. STATE	<u>Md.</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY	
<u>VICTORY Villa</u>	<u>RURAL</u>	<u>BALTIMORE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	20 COMPASS Rd.	d. STREET ADDRESS	5316 HOLDER AVE.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<u>ELLA</u>	<u>GERTRUDE</u>	<u>GIBSON</u>	<u>JAN. 12</u>
4. DATE OF DEATH	Month	Day	Year
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<u>Female</u>	<u>white</u>	<u>July 24, 1877</u>	9. AGE (In years from last birthday) <u>82</u> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Housewife</u>		11. BIRTHPLACE (State or foreign country)	
		<u>VIRGINIA</u>	
13. FATHER'S NAME		14. MOTHER'S MÄDEN NAME	
<u>HORACE Henry</u>		<u>SALLY ANN McGUFFIN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		INFORMANT	Address
		<u>MRS MELTA SHORT SAME</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<u>Congestive heart failure</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
4 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.			
DUE TO (b) <u>Arterio-sclerotic cardio vascular disease</u> DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I attended the deceased from <u>Sept. 1955</u> , to <u>Jan. 12, 1960</u> , that I last saw the deceased alive on <u>Jan. 12, 1960</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE		ADDRESS (Street, city or town, state) <u>Louis Semenoff</u> M.D. <u>2108 CREMIS RD</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <u>1/12/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM
<u>BURIAL</u>		<u>1/15/60</u>	<u>GLEN HAVEN</u>
22d. LOCATION (City, town, or county)		(State)	
<u>BALTIMORE</u>		<u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	24a. REC'D BY REGISTRAR
<u>LEONARD J. RUCK</u>		<u>5305 HARFORD RD</u>	<u>JAN 14 '60</u>
24b. REGISTRAR'S SIGNATURE		<u>Charles L. Thomas</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0395

## CERTIFICATE OF DEATH

Reg. Dist. No.

00284

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fullerton</b>		c. LENGTH OF STAY IN 1b <b>2 yrs,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>124 Leslie Ave</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>Rose</b>		First <b>M.</b>	Middle <b>Golombowski</b>
4. DATE OF DEATH <b>January 13, 1960</b>		Month <b>January</b>	Day <b>13</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>August 2, 1893</b>		9. AGE (in years last birthday) <b>66 yrs</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poland</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Rykowski</b>		14. MOTHER'S MAIDEN NAME <b>Mary Plewacki</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Frank Golombowski</b>		Address <b>124 Leslie Ave</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Hypertension</b> DUE TO <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hyperthyroid Disease</b> DUE TO <b>Cardio-Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>15 years</b>			
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Member</b>		20f. (City or town) <b>Towson</b> (County) <b>Baltimore</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Member</b> , 1949, to <b>January 12, 1960</b> , that I last saw the deceased alive on <b>January 12, 1960</b> , and that death occurred at <b>11:30 A.M.</b> from the causes and on the date stated above ACTUAL SIGNATURE <b>Melvin F. Polak</b> ADDRESS (Street, city or town, state) <b>3603 Belair Rd Baltimore 13 Md.</b> DATE SIGNED <b>1/15/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Stanislaus Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>George A. Weber</b>		ADDRESS <b>705 South Ann Street</b>	
		24a. REC'D BY REGISTRAR <b>JAN 15 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

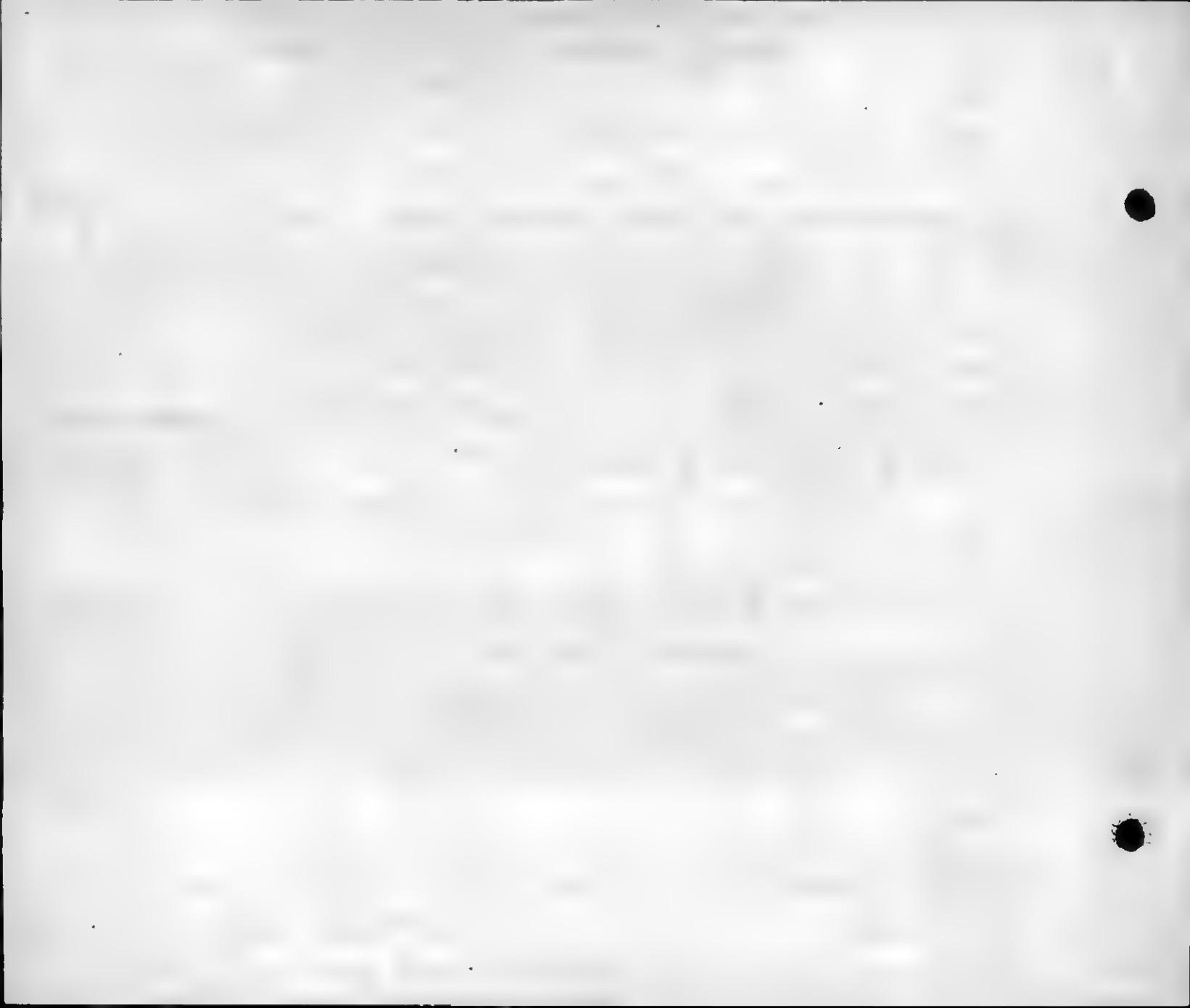
00285

Reg. Dist. No.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN lb <b>life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cockeysville</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bosley Avenue</b>		e. STREET ADDRESS <b>Bosley Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Ambrose Gordon</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>January 12, 1960</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	9. AGE (in years last birthday) <b>82 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. <b> </b>	11. IF UNDER 24 HRS. Months Days Hours Min. <b> </b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William H. Gordon</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Peterson</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-8237</b>		17. INFORMANT <b>Mrs. Julia Turnbaugh-Cockeysville</b>		Address <b>Warren Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		<i>Coronary Occlusion sudden</i>					
4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Charles F. Donnelly</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <i>Charles F. Donnelly</i>		DATE SIGNED <i>1/13/60</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Poplar Grove Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cockeysville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		ADDRESS <b>Towson 4, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 14 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0307 CERTIFICATE OF DEATH

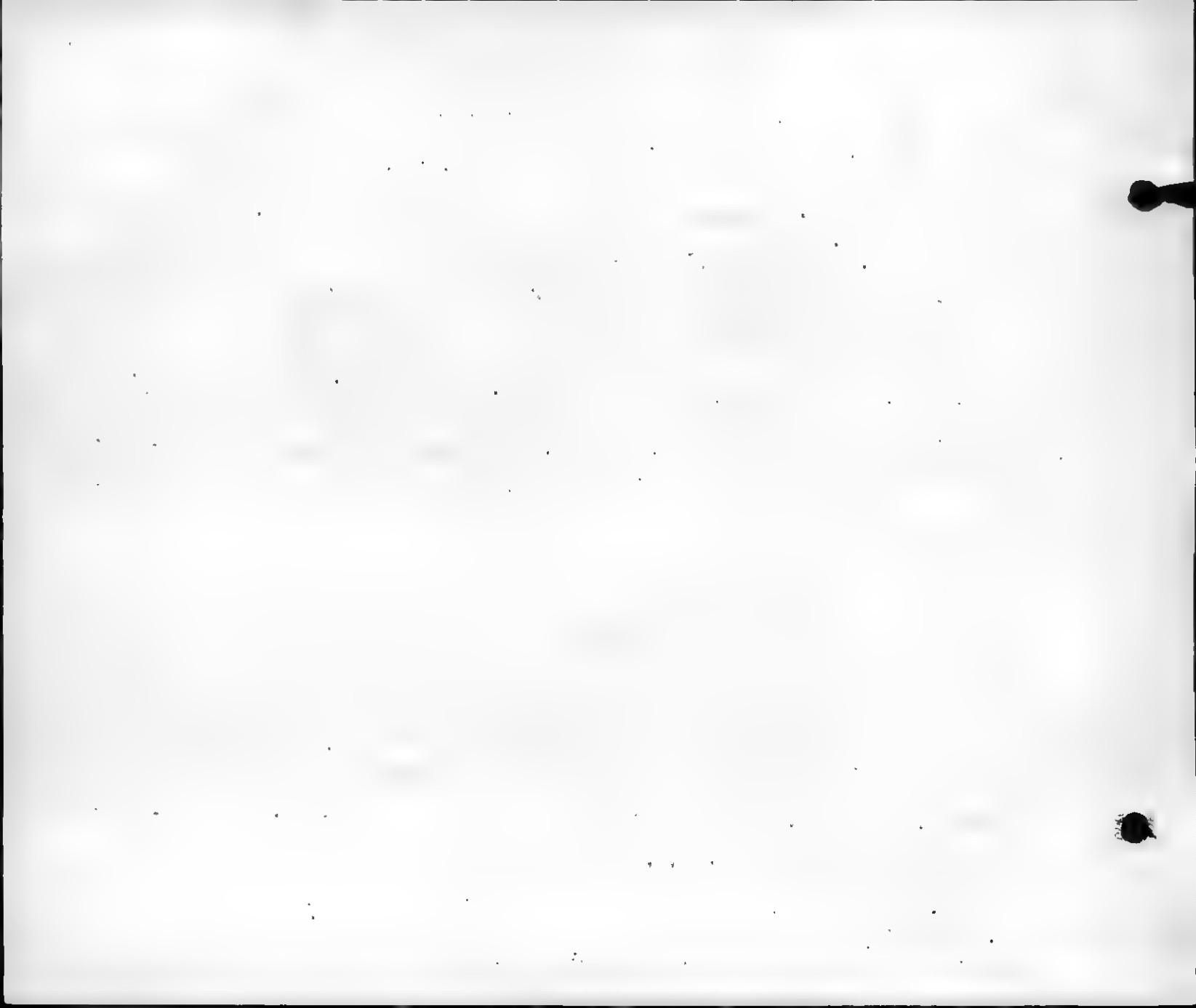
Reg. Dist. No.

06285

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Markton</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN TB <i>10 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Markton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Hereford.</i>		d. STREET ADDRESS <i>Hereford.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>John</i>	Middle <i>H.</i>	Last <i>Gosnell</i>
4. DATE OF DEATH	Month <i>January</i>	Day <i>24</i>	Year <i>1960</i>
5. SEX <i>M</i>	16. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <i>March 23, 1918</i>
9. AGE (In years, last birthday) yrs. <i>41</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Driver</i>	11. KIND OF BUSINESS OR INDUSTRY <i>Trucking</i>	12. CITIZEN OF WHAT COUNTRY? <i>A. S.A.</i>
13. FATHER'S NAME <i>Jesse F. Gosnell</i>	14. MOTHER'S MAIDEN NAME <i>Annie Standiford</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown) <i>No.</i>	
16. SOCIAL SECURITY NO. <i>218-14-8267</i>	17. INFORMANT <i>Mrs. Annie Gosnell, Markton, Md., R.D.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Hypertensive Cardio-Vascular Disease</i>	
DUE TO <i>443X</i>		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>December 2, 1958</i> , to <i>January 24, 1960</i> , that I last saw the deceased alive on <i>January 22, 1960</i> , and that death occurred at <i>8:20 A.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i>	
ACTUAL SIGNATURE <i>M.C. Porterfield</i>		DATE SIGNED <i>1/26/60</i>	
PHYSICIAN'S NAME (Type) <i>M.C. Porterfield, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 27, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Maryland Line Cem.</i>	22d. LOCATION (City, town, or county) <i>Maryland Line, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jacob Hartenstein, New Freedom, Pa.</i>	ADDRESS	24a. REC'D BY REGISTRAR <i>C. L. Kline</i>	24b. REGISTRAR'S SIGNATURE <i>C. L. Kline</i>
VS A15 (4) 15M 9/58		DATE JAN 28 '60	



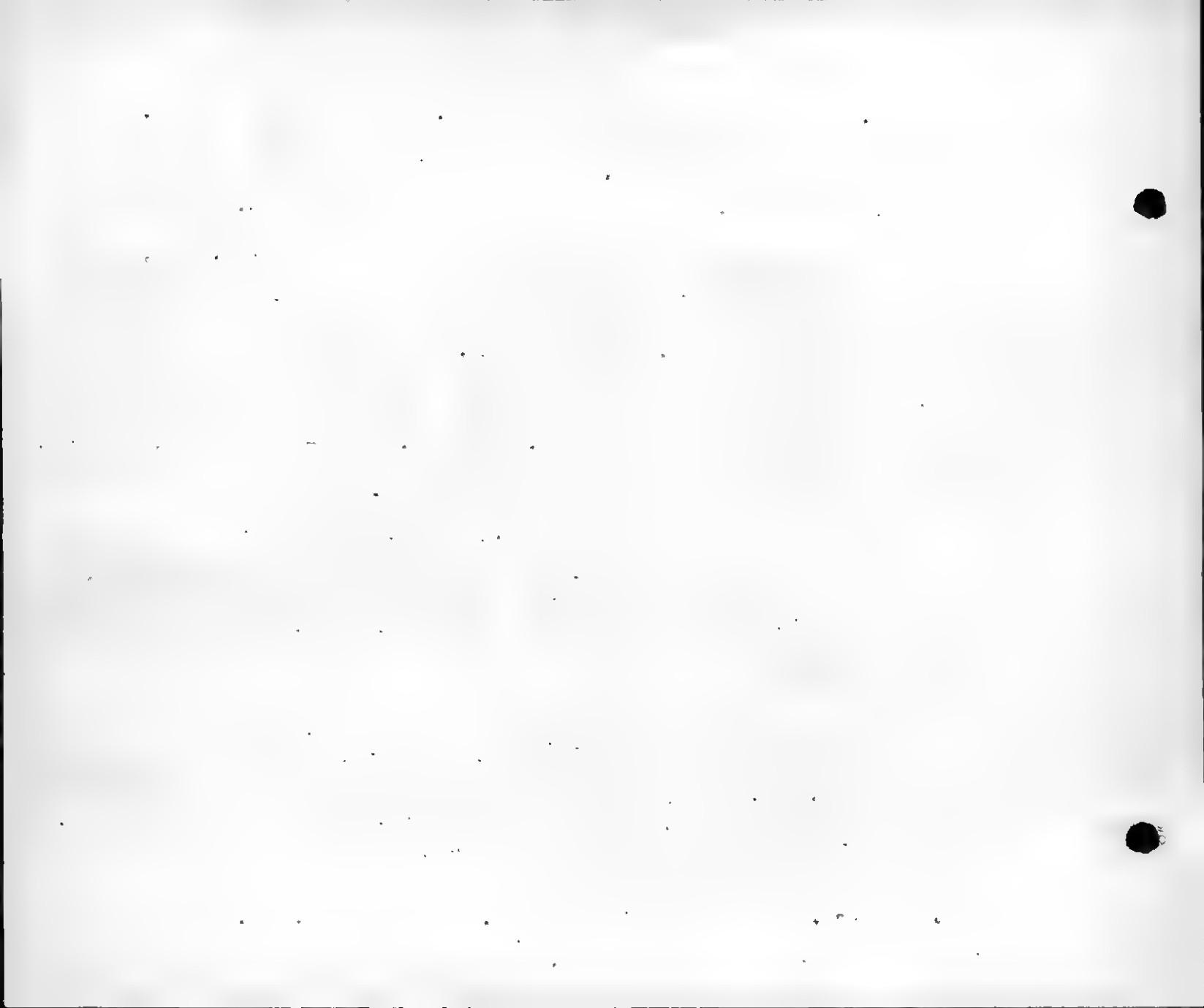
**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **00287**

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>55+</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>911 Locustvale Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>	
3. NAME OF DECEASED (Type or print) <b>Frank</b>		d. STREET ADDRESS <b>911 Locustvale Rd.</b>	
4. DATE OF DEATH <b>Jan. 6, 1960</b>		Month	Day
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 18, 1873</b>
9. AGE (In years last birthday) <b>86 yrs</b>		10. IF UNDER 1 YEAR Months <b>86</b>	11. IF UNDER 24 HRS Days <b>hrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ketired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mfct. Record</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>14. MOTHER'S MAIDEN NAME Amelia Mege</b>	
13. FATHER'S NAME <b>John R. Gould</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>16. SOCIAL SECURITY NO.</b>		INFORMANT <b>Mr. William M. Beury - Locust Vale, Towson 4, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>334X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <b>Congestive heart failure</b>		3 yrs.	
(c) DUE TO <b>Senility</b>		6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>Work</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Work</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 9th, 1941</b> to <b>Jan 6, 1960</b> , and that I last saw the deceased alive on <b>Jan 6, 1960</b> , and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Baltimore 18 Md</b>	
ACTUAL SIGNATURE <b>A.S. Chalfant</b>		DATE SIGNED <b>Jan 7 1960</b>	
PHYSICIAN'S NAME (Type) <b>A.S. CHALFANT</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 8, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Jm. J. Lickner Jr. Jan. 7 1960</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 7 '60</b>	
ADDRESS <b>111 Locustvale Rd.</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Trahan</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00288

## 0309 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN lb <b>26 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		d. STREET ADDRESS <b>309 NORTH GREENE STREET</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LOUIS</b>	Middle <b>T</b>	Last <b>GREEN</b>	4. DATE OF DEATH <b>JANUARY 9 1960</b>	Month Day Year		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>COLORED</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 10, 1918</b>		9. AGE (In years last birthday) <b>41</b> yrs.	If UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DISHWASHER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE T GREEN</b>		14. MOTHER'S MAIDEN NAME <b>MINNIE GREEN</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WW-11</b>		INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UNDIFFERENTIATED CARCINOMA MIDDLE EAR, RIGHT, WITH METASTASIS TO BRAIN</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>OTITIS MEDIA, CHRONIC</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>A</b> attended the deceased from <b>December 14, 1959</b> , to <b>January 9, 1960</b> , and that death occurred at <b>3:10 p.m.</b> from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>CHARLES ALLEN</b> DATE SIGNED <b>1-9-60</b>							
ACTUAL SIGNATURE		M.D. <b>VAH BALTO MD FT HOWARD DIV</b>					
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN</b>		M.D. <b>VAH BALTO MD FT HOWARD DIV</b> 1-9-60					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/13/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips Funeral Home</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Cinthus S. Krause</b>	
1808-10 N Monroe St, Baltimore 17, Md.							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00289

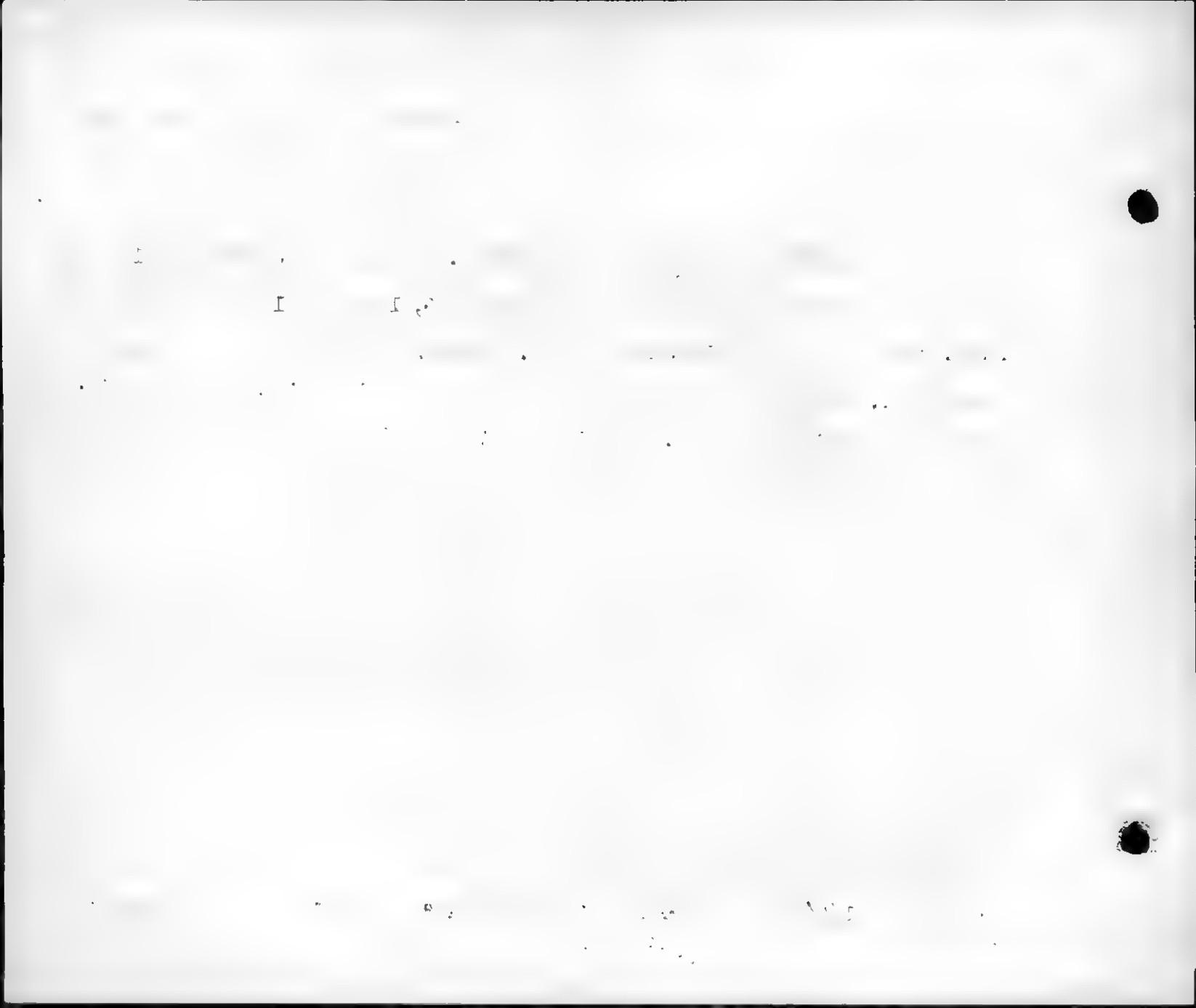
## 0310 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>BALTIMORE</b>										
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENCOE</b>		c. LENGTH OF STAY IN 1b /		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>GLENCOE</b>		d. STREET ADDRESS <b>GLENCOE ROAD</b>										
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GLENCOE ROAD</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>THOMAS CLAY GROTON SR.</b>		First	Middle	Last	4. DATE OF DEATH Month Day Year <b>JANUARY 1 1960</b>	Month	Day	Year								
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 3, 1898</b>	9. AGE (In years last birthday) <b>61 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POSTMASTER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
13. FATHER'S NAME <b>WILLIAM T. GROTON</b>				14. MOTHER'S MAIDEN NAME <b>VIRGINIA KATHERINE JOHNSON</b>												
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO YES</b>		16. SOCIAL SECURITY NO <b>NONE WVI 213-26-3238</b>		INFORMANT <b>FAHILY RECORDS</b>		Address										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertension</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH <b>Aug 5 to Jan 1</b>						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)														
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>GLENCOE</b>		(County)	(State)							
21. I certify that I attended the deceased from <b>Aug</b> , 19 <b>59</b> , to <b>Jan 12</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan 1st</b> , 19 <b>60</b> , and that death occurred at <b>12</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>Glencoe</b>	DATE SIGNED <b>Aug 5, 1960</b>					
ACTUAL SIGNATURE <b>R. Roy M. Polvost</b>										M.D.						
PHYSICIAN'S NAME (Type) <b>R. Roy M. Polvost</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>								22b. DATE THEREOF <b>1/4/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>IMMANUEL CHURCH CEMETERY</b>		22d. LOCATION (City, town, or county) <b>GLENCOE</b>		(State) <b>MARYLAND</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns Lewis</b>		ADDRESS <b>Towson, Md.</b>								24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00250

## 1. PLACE OF DEATH

a. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Towson

c. LENGTH OF STAY IN lb

6 Months

d. NAME OF HOSPITAL (If not in hospital, give street address of ED W. M. HAGAN

OR INSTITUTION

615 Chestnut Ave Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

4320 Roland Ave Baltimore Md.

b. COUNTY

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

BALTIMORE Md

? v 14

d. STREET ADDRESS

1404 W. Lexington St.

e. IS RESIDENCE

ON A FARM?

YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATH

Month

Day

Year

May

Louise Hagan

Jan 27

1930

5. SEX

FEMALE

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

May 3 1885

9. AGE (In years  
last birthday)

74 yrs.

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

DOMESTIC MAID.

13. FATHER'S NAME

EUGENE HAGAN

14. MOTHER'S MAIDEN NAME

ROSE GRUMBINE

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)

NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

219-30-8292

INFORMANT

Florence Windsor Stewart RN

Address

615 Chestnut Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

491X

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Bronchial Pneumonia

INTERVAL BETWEEN  
ONSET AND DEATH

1 week

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Carcinoma Colon, Colostomy

19. WAS AUTOPSY  
PERFORMED?YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year  
Hour o. m.  
p. m.20d. INJURY OCCURRED  
While  
at work  Not while  
at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from January 20, 1960, to January 27, 1960, that I last saw the deceased  
alive on Jan 26, 1960, and that death occurred at 5:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Maryland E. Day M.D. 4-2-33rd St - Baltw 18

PHYSICIAN'S  
NAME (Type)

Newland Edward Day MD

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

BURIAL

22b. DATE THEREOF

1-29-60

22c. NAME OF CEMETERY OR CREMATORI

Mt. Olivet Cemetery

22d. LOCATION (City, town, or county)

Baltimore

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

William Cook, Inc., 1217 St. Paul Street

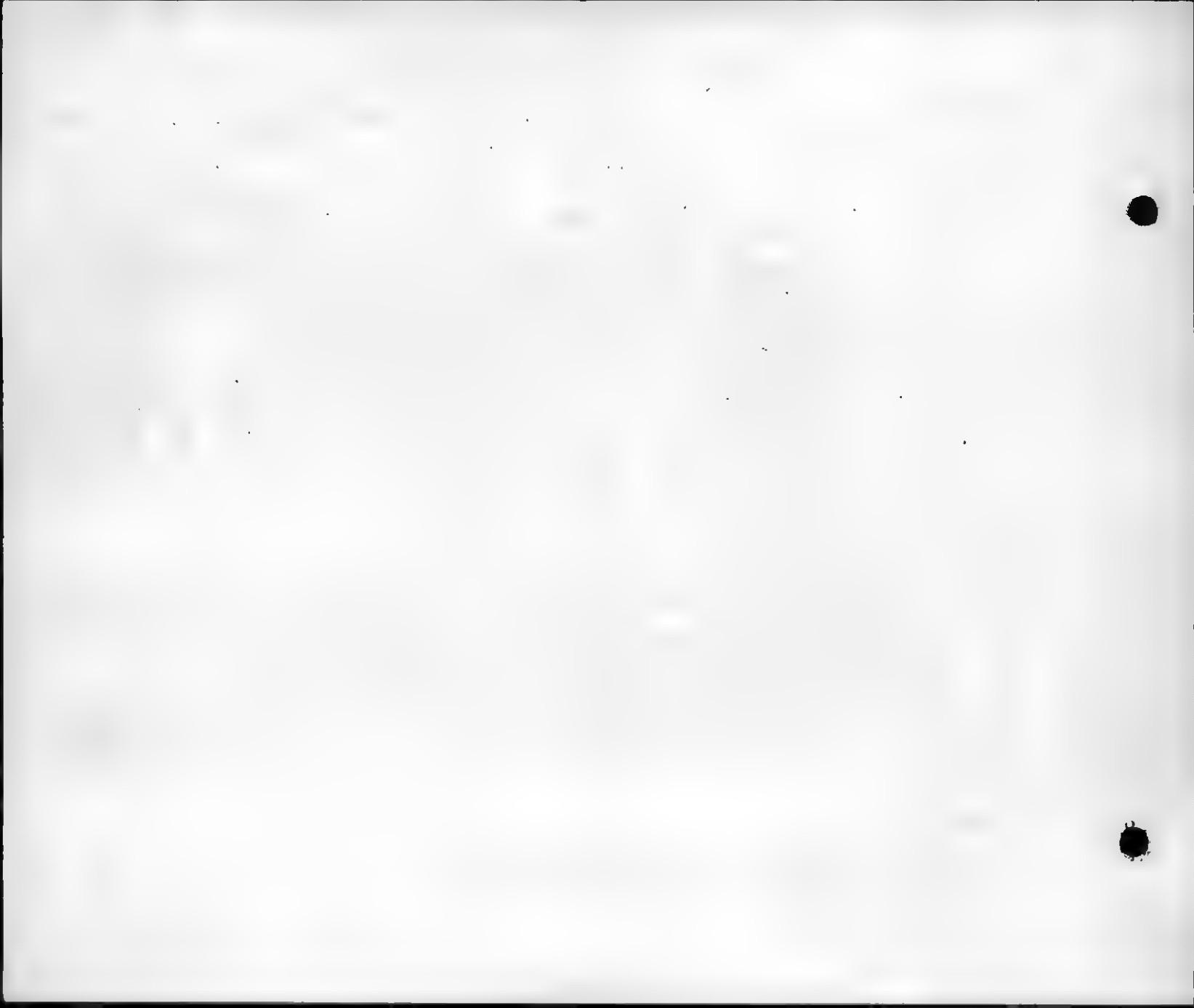
ADDRESS

24a. REC'D BY REGISTRAR

DATE JAN 28 '60

24b. REGISTRAR'S SIGNATURE

Arthur J. Keane



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

11/291  
32

1. PLACE OF DEATH a. COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>C Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Maryland</b>		c. LENGTH OF STAY IN 1b <b>10 weeks, 3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Manchester, N.H.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Mt. Wilson State Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>William</b>	Middle <b>Raymond</b>	Last <b>Hahn</b>	4. DATE OF DEATH Month <b>1</b>	Month <b>9</b>	Day <b>1960</b>	Year
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5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>3/3/1893</b>	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>	13. IF UNDER 24 HRS. Min. <b>0</b>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Md.</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
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13. FATHER'S NAME <b>Otto Hahn</b>	14. MOTHER'S MAIDEN NAME <b>Nancy Harris</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Hospital Records, Mt. Wilson State Hospital</b>	Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>For Advanced Pulmonary Tuberculosis</b>	INTERVAL BETWEEN ONSET AND DEATH <b>12 mo.</b>
Condition(s), if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) DUE TO	
Condition(s), if any, which gave rise to immediate cause (a), stating the underlying cause first. (c) DUE TO	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>10/12/51</b>	Day <b>1934</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>1934</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Mt. Wilson, Maryland</b>	20f. (City or town) <b>Mt. Wilson, Maryland</b>	(County) <b>Mt. Wilson, Maryland</b>	(State) <b>Md.</b>
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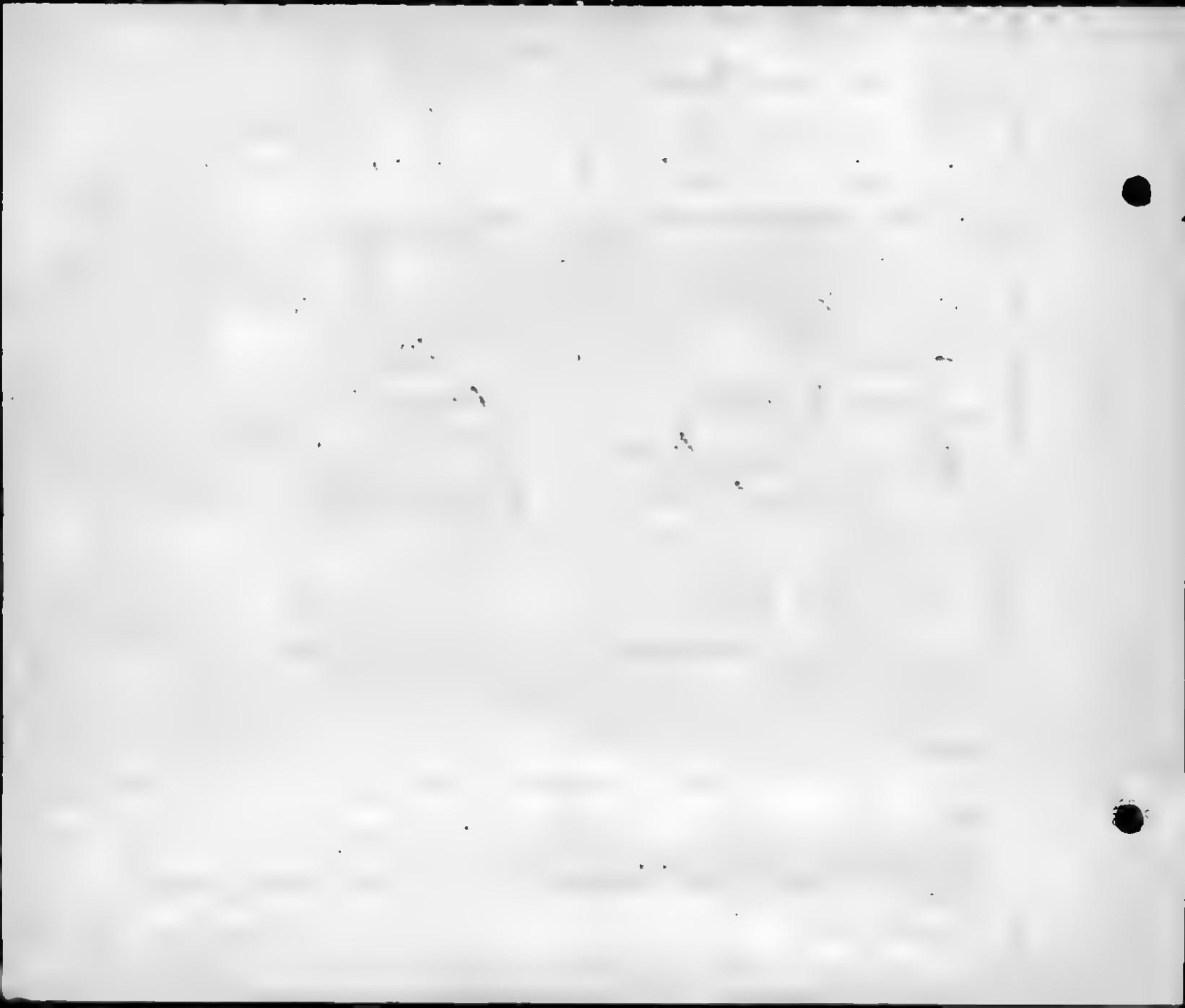
21. I certify that I attended the deceased from <b>10/12/51</b> , 1934, to <b>1/9</b> , 1960, that I last saw the deceased alive on <b>1/9</b> , 1960, and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above.
ADDRESS (Street, city or town, state)
DATE SIGNED

ACTUAL SIGNATURE	<b>Mt. Wilson, Maryland</b>
------------------	-----------------------------

PHYSICIAN'S NAME (Type)	<b>William Newcomer, M.D.</b>	Superintendent
-------------------------	-------------------------------	----------------

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan 12-1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Gravia Ridge Cemetery</b>	22d. LOCATION (City, town, or county) <b>Pikesville</b>	(State) <b>Md.</b>
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23. FUNERAL DIRECTOR'S SIGNATURE <b>Mr. Berryman &amp; Sons</b>	ADDRESS <b>Reisterstown, Md.</b>	24d. REC'D BY REGISTRAR DATE JAN 12 '60	24e. REGISTRAR'S SIGNATURE <b>C. L. Newcomer</b>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00292

## Baltimore County 0313 CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH COUNTY <i>Rosewood State Training School</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <i>MARYland</i> COUNTY <i>St. MARY County</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills M.D.</i>		c. LENGTH OF STAY IN 1b <i>7 years 4 mo</i> <i>11 days.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Douglas</i>	Middle <i>Wayne</i>	Last <i>HARE</i>
4. DATE OF DEATH	<i>1/23</i>		Month Year <i>January 1960</i>
S. SEX <i>Male</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>9/7/43</i>
9 AGE (In years last birthday) <i>16 yrs</i>	10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>921</i>		10b KIND OF BUSINESS OR INDUSTRY <i>—</i>
10c BIRTHPLACE (State or foreign country) <i>Maryland</i>	11. CITIZEN OF WHAT COUNTRY? <i>21-SA</i>		
13. FATHER'S NAME <i>Paul Sullivan HARE</i>	14. MOTHER'S MAIDEN NAME <i>Hazel Blackwell HARE</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i>	16. SOCIAL SECURITY NO <i>—</i>	INFORMANT <i>—</i>	Address <i>—</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Pneumonia</i> DUE TO <i>493X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) DUE TO INTERVAL BETWEEN ONSET AND DEATH <i>11 days</i>			
20c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 23, 1960</i> to <i>Jan 23, 1960</i> that I last saw the deceased alive on <i>Jan 22, 1960</i> and that death occurred at <i>4 M.</i> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>ADDRESS</i> DATE SIGNED <i>1/23/60</i>			
ACTUAL SIGNATURE <i>Stanley G. Butler</i> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan. 26, 1960</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Oconee Memorial Park</i>	22d. LOCATION (City, town, or county) (State) <i>Oconee, South Carolina</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Eline &amp; Sons, Reisterstown, Md.</i>		ADDRESS <i>—</i>	24a. REC'D BY REGISTRAR DATE <i>JAN 26 '60</i>
			24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. - Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS ATS (4)  
1SM 10/57

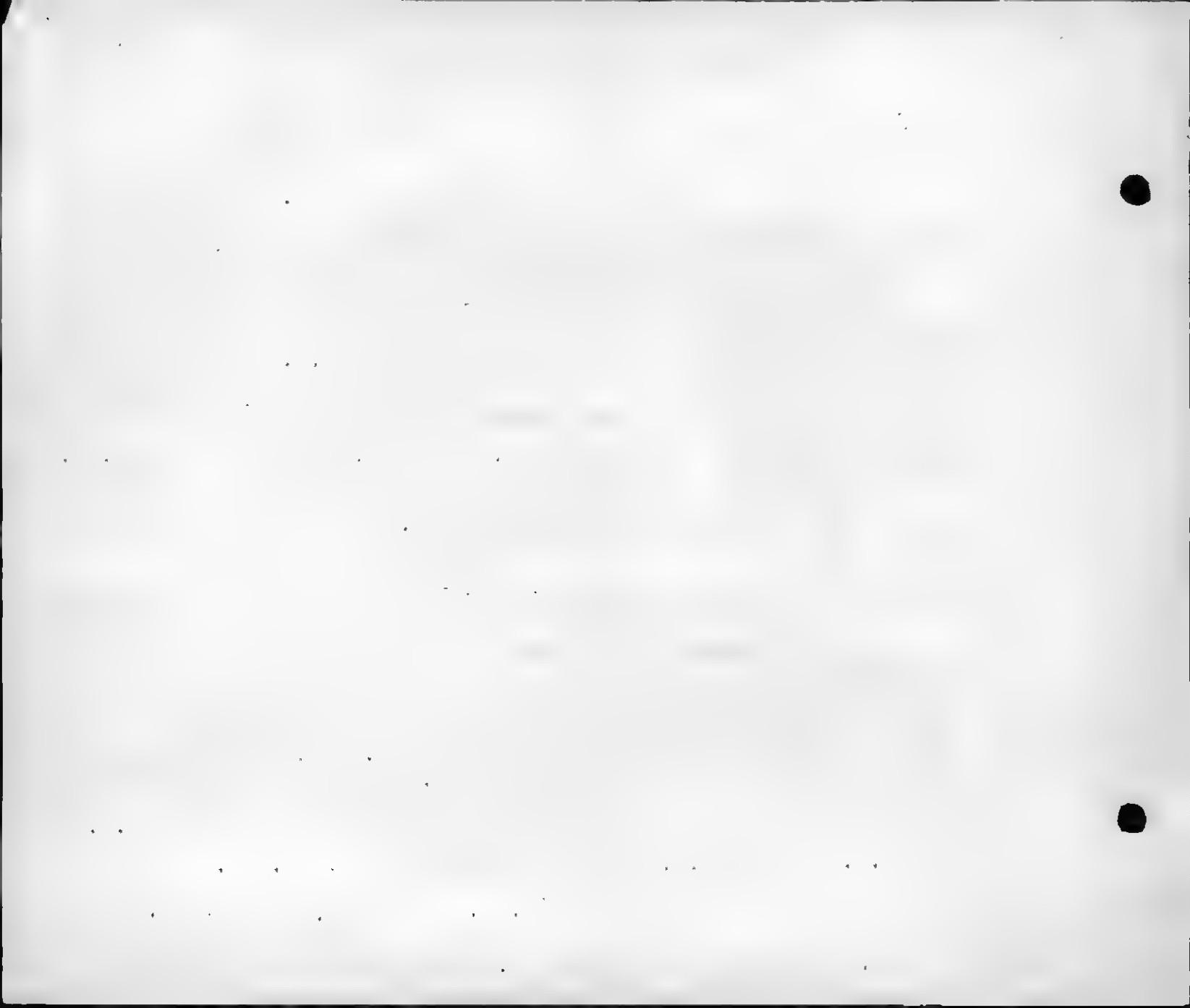
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0314 CERTIFICATE OF DEATH

00293

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>M.D.</b>		b. COUNTY <b>BALTIMORE</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN 1b <b>30 YRS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		d. STREET ADDRESS <b>1009 ALEXANDER AV.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>EDWARD</b>	Middle <b>HARRIS (HARRIES)</b>	Last <b></b>	4. DATE OF DEATH <b>1-5-60</b>	Month <b>1</b>	Day <b>5</b>	Year <b>60</b>	
S. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-12-1892</b>		9. AGE (In years' lost birthday) <b>67</b> yrs.	10. IF UNDER 1 YEAR: IF UNDER 24 HRS. Months <b></b> Days <b></b> Hours <b></b> Min <b></b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LADDERER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PAPER MILL</b>		11. BIRTHPLACE (State or foreign country) <b>LONGBRANCH, N.J.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>GEORGE HARRIS (HARRIES)</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE WASHINGTON</b>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>14-18-9441</b>		17. INFORMANT <b>Mrs. NETTIE H. PAGE (D) 1009 ALEX. AV.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>421.0</b>		DUE TO <b>Broncho-pneumonia</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 days</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)		DUE TO <b>Mitral Insufficiency</b>				82 days			
(c) Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		Hypertensive Arterio-sclerosis				?			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>Oct-15th</b> , 19 <b>59</b> , to <b>Jan. 5th</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan. 5th</b> , 19 <b>60</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>G.F. Maloney</b>		M.D.		ADDRESS (Street, city or town, state) <b>57 Winters Lane</b>		DATE SIGNED <b>Jan. 5, 60</b>			
PHYSICIAN'S NAME (Type) <b>G.F. Maloney, M.D.</b>				Catoonsville, 28. Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>ARLINGTON CEM. L.D.</b>		22d. LOCATION (City, town, or county) <b>ARLINGTON, MD.</b>		(State) <b></b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. COOPER</b>		ADDRESS <b>Baltimore, MD.</b>		24a. RECEIVED BY REGISTRAR <b>JAN 7 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Frame</b>			



X

FOR STATE  
HEALTH DEPT.MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

00294

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be filed within 21 days after death. If only day is necessary, please execute the certificate, writing the word "opening" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-trust permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>N.Y.</i> b. COUNTY <i>Bronx</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>3 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>2820 Arlene Circle</i>		e. STREET ADDRESS <i>1521 Unionport Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>KATHRYN</i>		First <i>L.</i>	Middle <i>Hassett</i>
4. DATE OF DEATH <i>Jan 1 1960</i>		Lost <i>June 12, 1880</i>	Month <i>73 yrs.</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		9. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
10. BIRTHPLACE (State or foreign country) <i>Brown</i>		11. BIRTHDATE (Age in years, month, day) <i>73 yrs.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>John Winkler</i>	
14. MOTHER'S MAIDEN NAME <i>Marg. Healy</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>V.A. H. Best. 2820 Arlene Circle</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. INTERVAL BETWEEN ONSET AND DEATH <i>3 yrs.</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Angina Pectoris</i>		DUE TO <i>None</i>	
Conditions, if any, which gave rise to immediate cause (b) <i>None</i>		DUE TO <i>None</i>	
DUE TO <i>None</i>		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <i>None</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>Nov 19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/> <i>None</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>D.D. Caples</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>D.D. CAPLES MD</i>		DATE SIGNED <i>1-1-'60</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>Jan. 5, 1960</i>	
22g. NAME OF CEMETERY OR CREMATORIAL <i>Gate of Heaven Cemetery</i>		22h. LOCATION (City, town, or county) (State) <i>West Chester Co., New York</i>	
23. MINERAL DIRECTOR'S SIGNATURE <i>Elsworth Armacost</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 4 '60</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			
VS. A15ME 5M 2/57			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00295

## 0316 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cotonsville</i>		c. LENGTH OF STAY IN lb <i>3 Wks.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Pasadena (North Shore)</i>		d. STREET ADDRESS <i>Edgewater Rd. - R.H. Box 214A</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>House In The Pines Conv. Home</i>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Philip</i>		First	Middle <i>M.</i>	Last <i>Hayden</i>	4. DATE OF DEATH <i>January 2</i>	Month <i>January</i>	Day <i>2</i>	Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>8 Nov 1865</i>	9. AGE (in years last birthday) <i>94 yrs</i>	10. UNDER 1 YEAR Months <i>0</i>	11. UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Customs Insp. (Ret.)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Treas. Dept.</i>		11. BIRTHPLACE (State or foreign country) <i>St. Mary's Co., Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Unknown (Hayden)</i>		14. MOTHER'S MARRIED NAME <i>Unknown</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mr. Jesse Dunwoody</i>		Address <i>Same As #2</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congruency of opinion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Severe arterio sclerotic vascular</i> (c) <i>Perfus. Vascular Disease</i>									
INTERVAL BETWEEN ONSET AND DEATH									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Sensibility</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Dec 15, 1953, to Jan 2, 1960</i>							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <i>Baltimore</i>		(County) <i>Baltimore</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Dec 15, 1953, to Jan 2, 1960</i> that I last saw the deceased alive on <i>Aug 20, 1960</i> , and that death occurred at <i>10 A.M.</i> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <i>3033 W North St., Baltimore, Md.</i>									
DATE SIGNED <i>1/7/60</i>									
ACTUAL SIGNATURE <i>Al Paul</i>		M.D.							
PHYSICIAN'S NAME (Type) <i>M. Paul</i>		3033 W North St., Baltimore, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5 Jan 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>New Cathedral Cem.</i>		22d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. T. Brighton</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR <i>JAN 7 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Alma L. Thomas</i>			

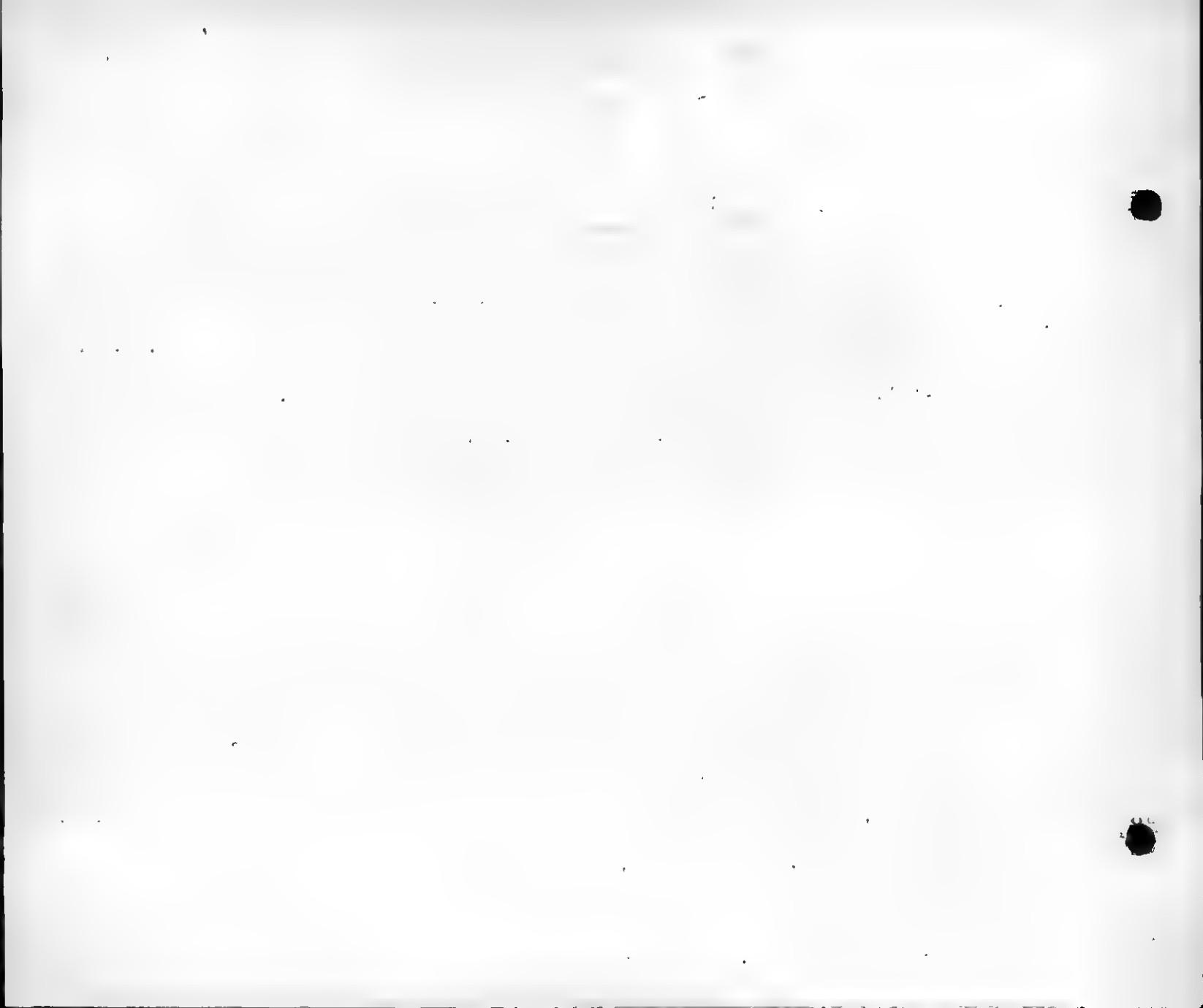


00296

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-used by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

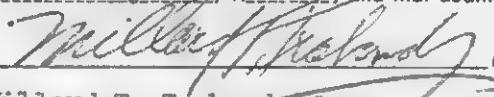
<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>														
<b>CERTIFICATE OF DEATH</b>														
<b>1. PLACE OF DEATH</b> a. COUNTY      Baltimore      MARYLAND					b. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland      b. COUNTY									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville					c. LENGTH OF STAY IN 1b 15yr1mth15dys									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL					e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore									
f. STREET ADDRESS Hillsdale, Maryland														
g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
<b>3. NAME OF DECEASED</b> (Type or print)		First	Middle	Last	<b>4. DATE OF DEATH</b> January 24, 1960		Month	Day	Year					
h. SEX female		6 COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 28, 1888	9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office worker					10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME Michael Hennessey					14. MOTHER'S MAIDEN NAME Catherine Doyle									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)      no					16. SOCIAL SECURITY NO. Unknown					17. INFORMANT Records: SPRING GROVE STATE HOSPITAL				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)      Terminal bronchopneumonia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)      Arteriosclerotic cardiovascular disease DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
<b>MEDICAL CERTIFICATION</b>					20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m.      19 p. m.					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.) 20f. (City or town) (County)      (State)				
21. I certify that I attended the deceased from _____ July 1, 1955, to Jan. 24, 1960 that I last saw the deceased alive on Jan. 24, 1960 and that death occurred at 6:00 AM, from the causes and on the date stated above. ACTUAL SIGNATURE      Stella Wachsler, M.D.      ADDRESS (Street, city or town, state)      DATE SIGNED 5.25.60														
PHYSICIAN'S NAME (Type)					Physician's Name					Catonsville 28, Maryland				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 1-27-60					22c. NAME OF CEMETERY OR CREMATORIAL Cathedral Cem				
23. FUNERAL DIRECTOR'S SIGNATURE Farley Funeral Home, Catonsville, Md.					ADDRESS					24a. REC'D BY REGISTRAR Date JAN 28 '60				
										24b. REGISTRAR'S SIGNATURE Arthur S. Kraus				

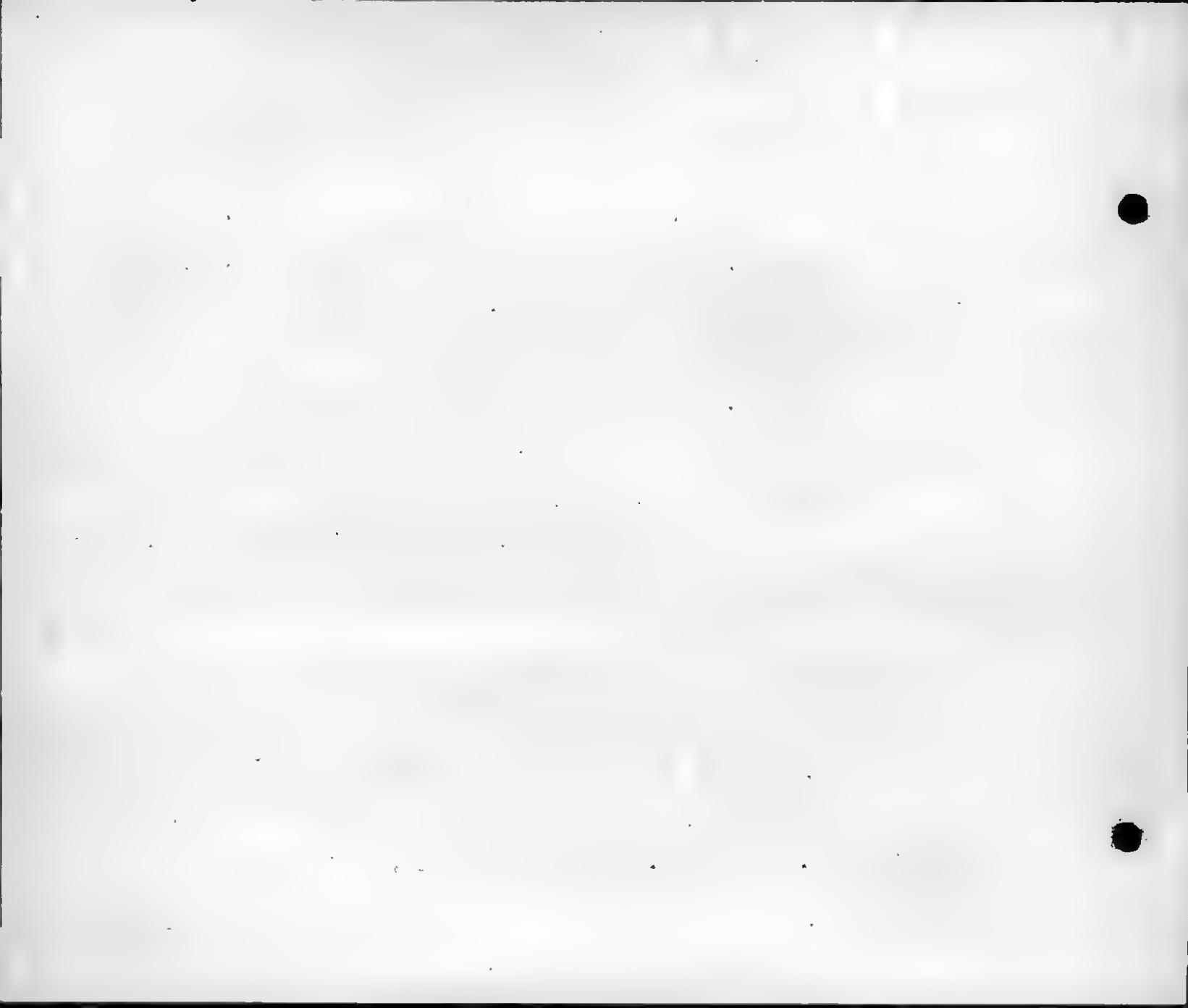


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**

**0310 CERTIFICATE OF DEATH**

Reg. Dist. No. **00297**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>6908 Windsor Mill Rd.</b>				d. STREET ADDRESS <b>6908 Windsor Mill Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>George E. Henritz</b>		First	Middle	Last	4. DATE OF DEATH <b>Jan. 17</b>	Month	Day	Year <b>19 60</b>		
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1885</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>George Henritz, Sr.</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth Subock</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Maude M. Henritz</b>		Address <b>6908 Windsor Mill Rd.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>				
Arteriosclerotic cardiovascular disease						10 years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Emphysema</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****								
20c. TIME OF INJURY Month, Day, Year ***** 19		20d. INJURY OCCURRED While <input type="checkbox"/> At home <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) *****		(County) *****	(State) *****	
21. I certify that I attended the deceased from <b>January 13, 1960</b> , to <b>January 18, 1960</b> , that I last saw the deceased alive on <b>13 January 1960</b> , and that death occurred at <b>5:30P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>5101 Gwynn Oak Ave</b>				DATE SIGNED <b>1/18/60</b>
ACTUAL SIGNATURE 		M.D.								
PHYSICIAN'S NAME (Type) <b>Millard T. Traband, Jr.</b>		Baltimore, 7, Maryland								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 20, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Woodlawn</b>		22d. LOCATION (City, town, or county) <b>Woodlawn</b>		(State) <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John T. Stansbury</b>		ADDRESS <b>6411 Windsor Mill Rd.</b>		24a. REC'D BY REGISTRAR <b>JAN 13 1960</b>		24b. REGISTRAR'S SIGNATURE 				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

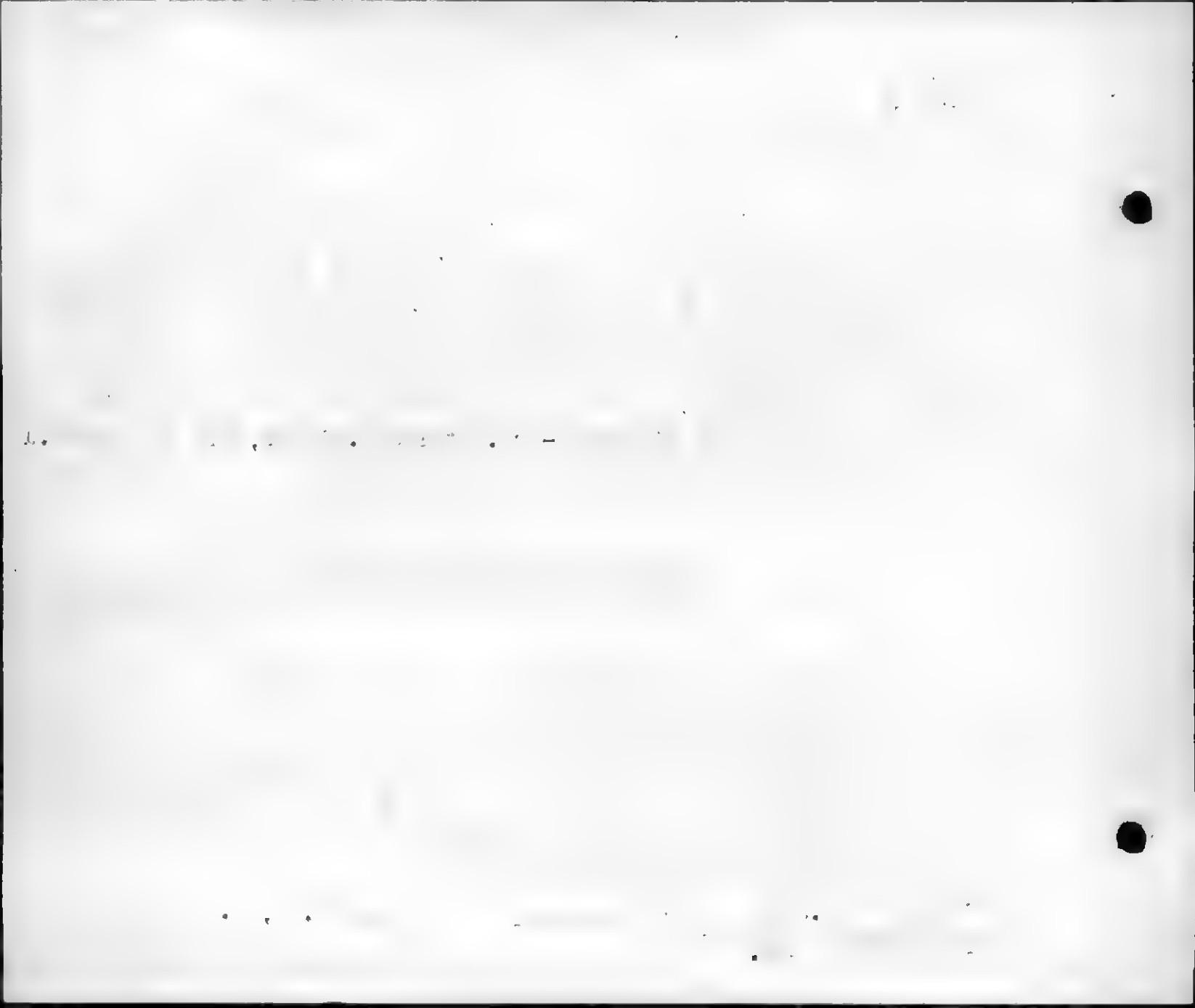
00298

Baltimore County

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Baltimore County</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Res'dence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrison</b>		c. LENGTH OF STAY IN lb		a. STATE <b>Maryland</b>	
NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Foxley Conv. Home.</b>		c. CITY OR TOWN (If out'side corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		b. COUNTY	
3. NAME OF DECEASED (Type or print) <b>HARRY Joseph</b>		First	Middle	Last	4. DATE OF DEATH <b>JANUARY 30<sup>th</sup> 1960</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV 15 1879</b>	9. AGE (In years last birthday) <b>80 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CHEF</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>620 Ramrod</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Frank B. Henry.</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE MADDEN</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>705 05 3103</b>		INFORMANT <b>A-Mrs. Estelle H. Miller, 4416 Old Fredk. Rd</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <b>BRONCHOPNEUMONIA</b> INTERVAL BETWEEN ONSET AND DEATH <b>26 Days</b>					
33IX Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last		(b) DUE TO			
		(c) DUE TO	<b>CEREBRAL VASCULAR ACCIDENT</b> 8 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACC DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that I attended the deceased from <b>Dec 7, 1959</b> , to <b>Jan 30, 1960</b> , that I last saw the deceased alive on <b>Dec 30, 1960</b> , and that death occurred at <b>7:45 AM</b> , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <b>Francis T. Daly, M.D., 1725 Riverfront Parkway, Baltimore, Md.</b> DATE SIGNED					
ACTUAL SIGNATURE <b>Francis T. Daly</b>					
PHYSICIAN'S NAME (Type) <b>Francis T. Thomas Daly</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 3/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S ADDRESS <b>White Funeral Directors 4101 Edmondson Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Christine S. Evans</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

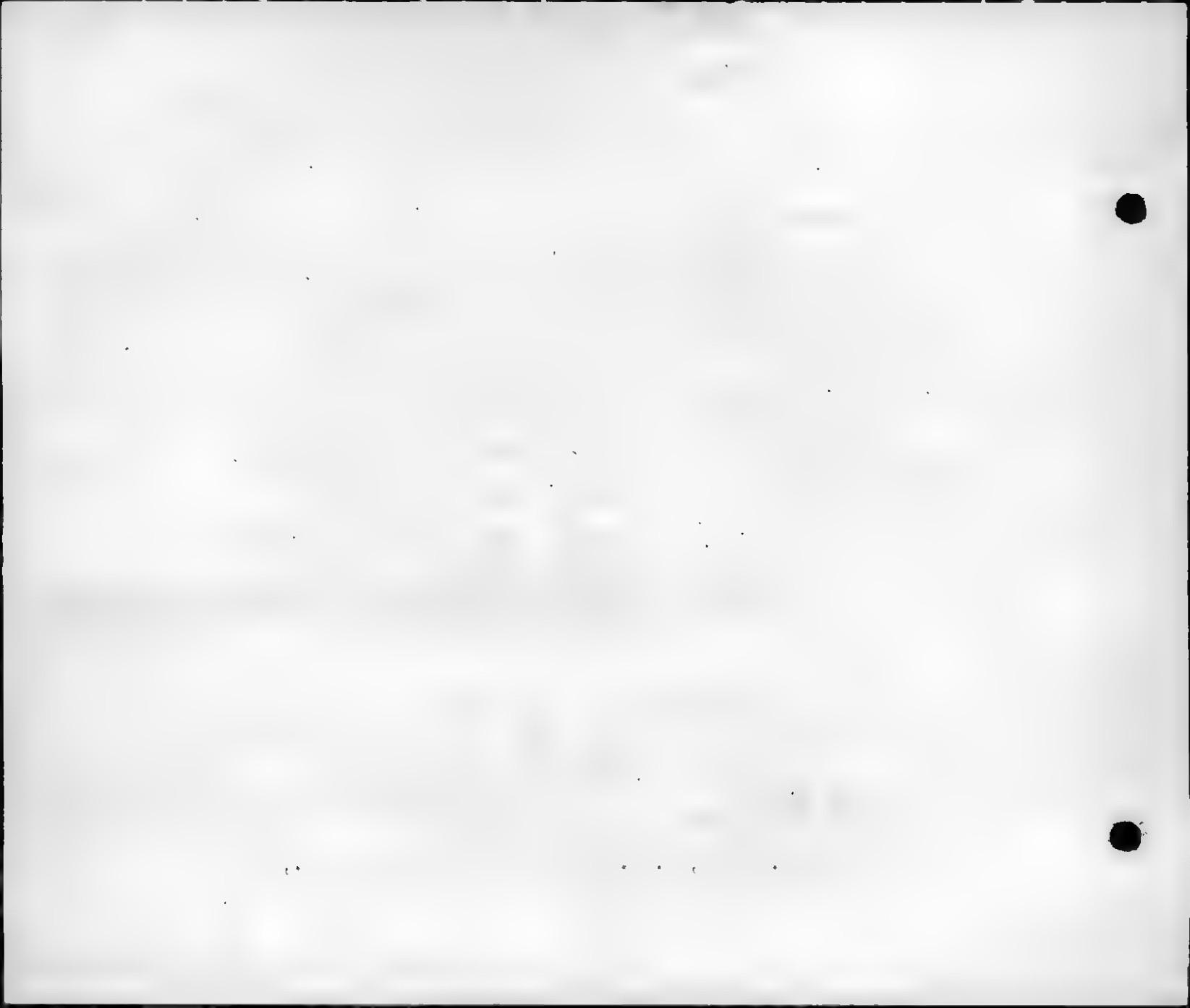
**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

00299

0320

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lutherville</i>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		d. STREET ADDRESS <i>3611 Helston Dr. 29</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Forest Haven Conv. Home</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Rachel L. Hildebrand</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan 28 1960</i>	Month	Day	Year	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/16/90</i>		9. AGE (In years last birthday) <i>69 yrs</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during busy of working life, even if retired) <i>Homemaker</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Jacob Zweedale</i>		14. MOTHER'S MAIDEN NAME <i>Linwood J. Tall</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>260X</i>		17. INFORMANT <i>Linwood J. Tall</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial insufficiency</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>DUE TO</i>		(b) <i>arterio-sclerotic cardiovascular disease</i>							
		(c) <i>Diabetes mellitus</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>London Park</i>		20f. (City or town) <i>Baltimore</i>		(County) <i>Md.</i>	(State) <i>Md.</i>
21. I certify that (I) (this hospital) attended the deceased from <i>Apr 8 1958</i> to <i>Jan 28 1960</i> , that (II) (we) last saw the deceased alive on <i>Jan 28 1960</i> , and that death occurred at <i>1 p.m.</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>George A. Knipp</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>						22b. DATE SIGNED <i>Feb 1 1960</i>	
22c. PHYSICIAN'S NAME (Type) <i>George A. Knipp, M. D.</i>		22d. ADDRESS <i>4116 Edmondson Ave.</i>							
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>3/11/60</i>		23c. NAME OF CEMETERY OR CREMATORIUM <i>London Park</i>		23d. LOCATION (City, town, or county) <i>Baltimore</i>		(State) <i>Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Donald Knipp</i>		ADDRESS <i>112 Madrabb St don 28</i>		25a. REC'D BY REGISTRAR <i>Feb 1 '60</i>		25b. REGISTRAR'S SIGNATURE <i>Charles S. Knapp</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

00350

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore		Rosewood State Training School MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o. STATE Maryland		b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN 1b 5½ months		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen, Maryland		d STREET ADDRESS ---- 55 Taft Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Danny		First	Middle	Lost	Hinckle	4. DATE OF DEATH 1	Month Day Year 31 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-19-59		9. AGE (In years last birthday) yrs 7 13	IF UNDER 1 YEAR Months Days Hours 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----		10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David T. Hinckle				14. MOTHER'S MAIDEN NAME Shirley Frances Meadows			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ----		16. SOCIAL SECURITY NO ----		INFORMANT Rosewood Records		Address 3411	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Marked hydrocephalus and</i> <i>751 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>meningo-myelitis complicated</i> (c) <i>by left purulent otitis media</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <i>11:50pm</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>C.W. Rieckert M.D.</i> ADDRESS (Street, city or town, state) DATE SIGNED <i>Baltimore 14, Md. 2-3-60</i>							
PHYSICIAN'S NAME (Type) <i>P.W. Rieckert</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb. 4, 60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Rosewood Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Owings Mills, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.F. Eline &amp; Sons Reisterstown, Md.</i>		ADDRESS 24a. REC'D BY REGISTRAR DATE <i>FEB 5 '60</i> 24b. REGISTRAR'S SIGNATURE <i>Arthur L. Knapp</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File No. 1-21-60 et

0332

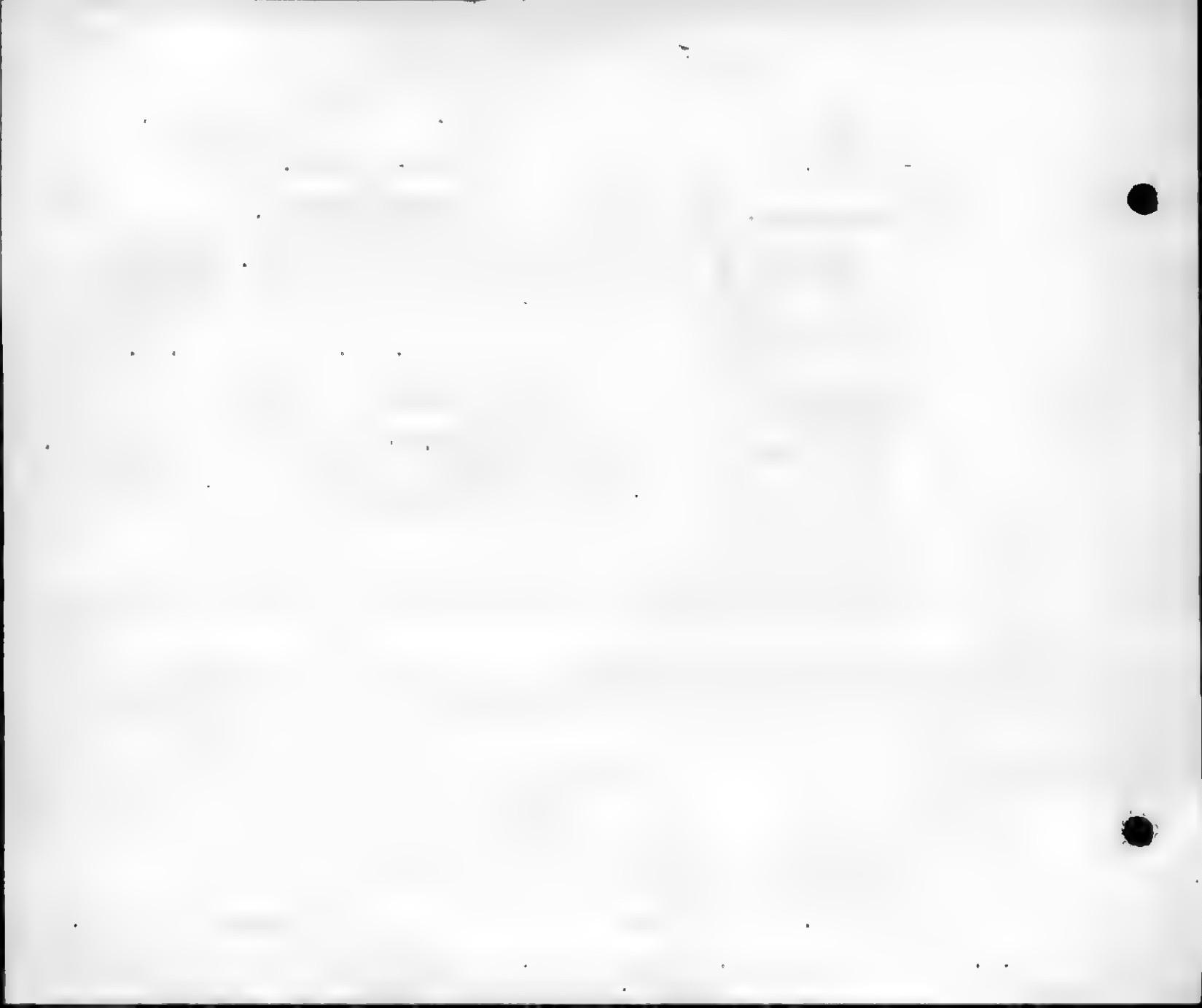
## CERTIFICATE OF DEATH

Reg. Dist. No.

00301

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be relayed by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Balto.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Balto.</b>		c. LENGTH OF STAY IN 1b <b>609 Murdock Rd.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Balto.</b>		d. STREET ADDRESS <b>609 Murdock Rd.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>609 Murdock Rd.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Elizabeth</b>		First	Middle	Last	4. DATE OF DEATH <b>Jan. 16 1960</b>	Month	Day	Year	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1862</b>	9. AGE (In years last birthday) <b>97 1/2 yrs.</b>	IF UNDER 1 YEAR Months <b>97 1/2</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>John Hodes</b>		14. MOTHER'S MAIDEN NAME <b>Avelena Grieser</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>Margaret M. Hodes</b>		Address <b>609 Murdock Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO <i>Cysto-ureticic Carditis as near known 10 yrs.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>	(State)
21. I certify that I attended the deceased from <b>Nov. 4, 1954</b> to <b>Jan. 14, 1960</b> , that I last saw the deceased alive on <b>Jan. 14, 1960</b> , and that death occurred at <b>4 P.M.</b> from the causes and on the date stated above.									
ADDRESS (Street, city or town, state) <b>609 Murdock Rd. Baltimore, Md.</b>									DATE SIGNED <b>Jan. 18 '60</b>
ACTUAL SIGNATURE <i>Wm H. Kammery Jr.</i>									
PHYSICIAN'S NAME (Type) <b>H.W. Jenkins &amp; Sons Co.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 19, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>New Cathedral</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co. 4905 York Rd.</b>		ADDRESS <b>Balto. 12, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>E. L. Kammery</i>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0323 CERTIFICATE OF DEATH

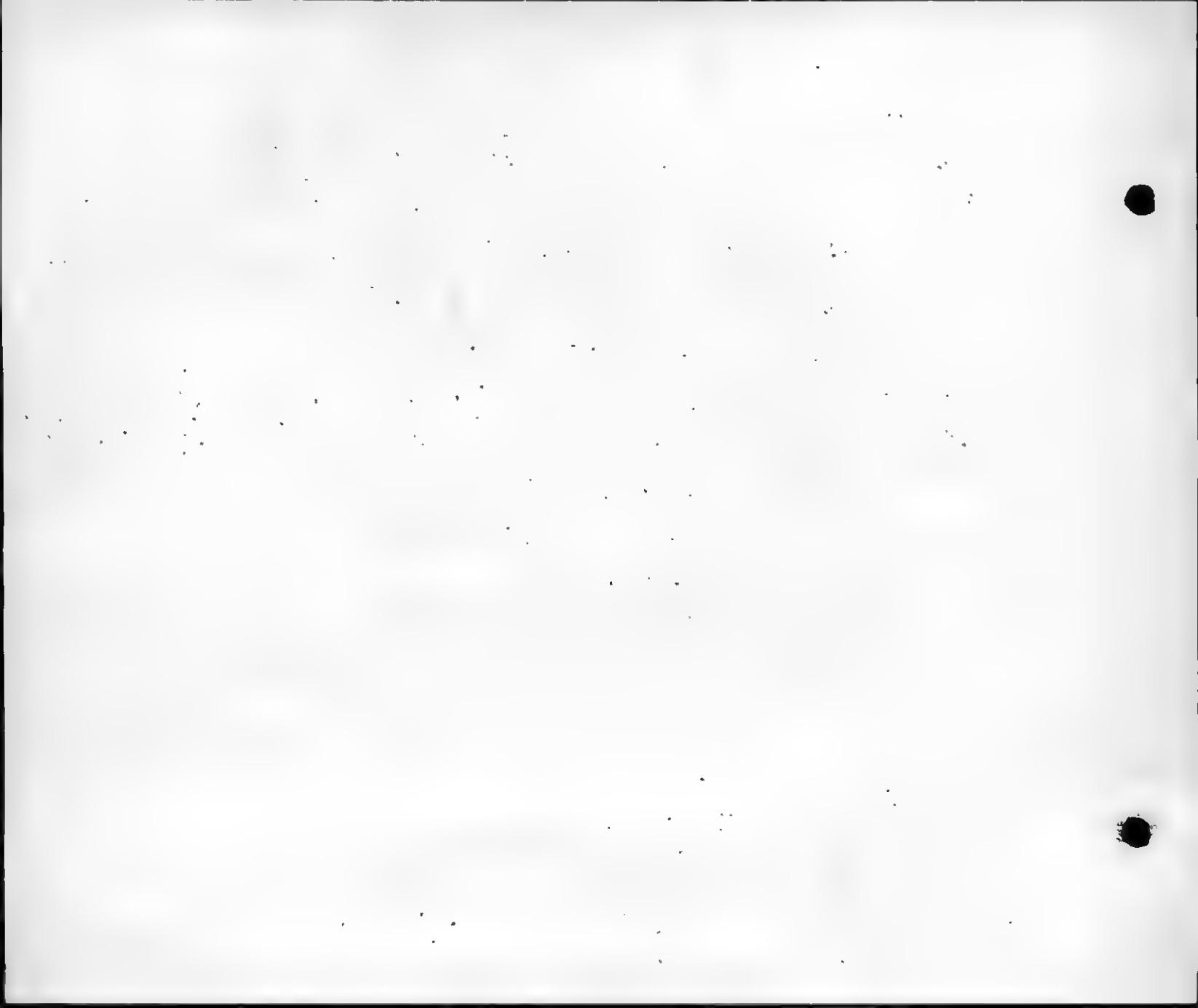
Reg. Dist. No.

00302

**TO HOSPITAL** or **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY		Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)		Md.		b. STATE COUNT		Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural-Millers.		c. LENGTH OF STAY IN 1b		50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural-Millers.		d. STREET ADDRESS		Bollinger Rd.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Bollinger Rd.						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		Annie E. Hoffman		First Middle		Last		4. DATE OF DEATH		January		Month		Day Year			
5. SEX		F		6 COLOR OR RACE		W		7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		July 1 1884		9 AGE (In years less birthday) 75 yrs		10 UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Housewife		10b. KIND OF BUSINESS OR INDUSTRY		Own home		11. BIRTHPLACE (State or foreign country)		Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY?		U. S. A.			
13. FATHER'S NAME		John Cooper		14. MOTHER'S MAIDEN NAME		Rebecca Williams.		INFORMANT		William A. Hoffman, Millers, Md.		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		No		16. SOCIAL SECURITY NO				17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Cerebral hemorrhage		INTERVAL BETWEEN ONSET AND DEATH		24 hrs			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a).				DUE TO		(b)		arteri sclerosis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO		(c)		163 furturism									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)					
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.														ADDRESS (Street, city or town, state)			
ACTUAL SIGNATURE		A. M. France		M.D.										DATE SIGNED			
PHYSICIAN'S NAME (Type)		A. M. France												1/4/60			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI				22d. LOCATION (City, town, or county)									
Burial, Jan. 7 1960				Middleton Cemetery		Freeland, Md.											
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE							
Jacob Hartenstein, New Freedom, Pa.								DATE JAN 6 '60		Arthur S. Kline							



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0324

## CERTIFICATE OF DEATH

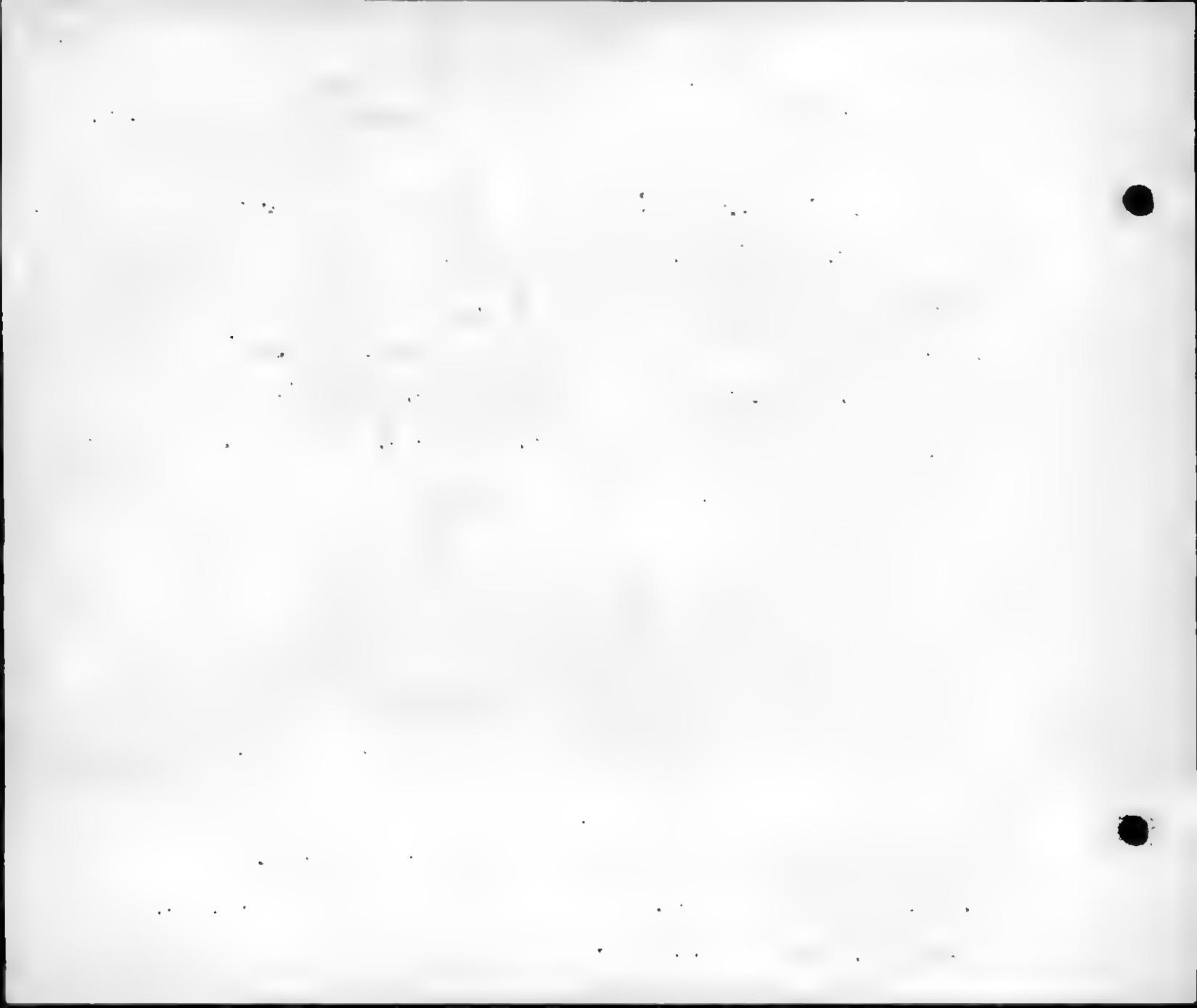
Reg. Dist. No.

00303

**TO HOSPITAL** ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE		Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		X Parkville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2530 Wentworth Road		d. STREET ADDRESS		2530 Wentworth Road			
3. NAME OF DECEASED (Type or print)		First Mrs. Elsie G.	Middle	Last Hogan	4. DATE OF DEATH	Month January	Day 4 Year 1960		
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
female		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Oct. 21, 1901	58 yrs.	Months	Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Housewife				Baltimore, Maryland		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
William J. Armstrong		Annie G. Maxfield							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address			
[If yes, give war or dates of service]				Mr. Joseph R. Hogan, Sr.		same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 Minutes</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from _____ alive on _____, and that death occurred at _____ from the causes and on the date stated above.		ADDRESS (Street, city or town, state)							
ACTUAL SIGNATURE <u>Harold A Burns</u> M.D. <u>8116 Harford Rd</u> <u>1-4-60</u>		DATE SIGNED							
PHYSICIAN'S NAME (Type) <u>Harold Burns</u>		<u>Baltimore, Maryland</u> <u>1/4/1960</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1/18/1960</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Baltimore National</u>		22d. LOCATION (City, town or county) <u>Baltimore, Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck</u>		ADDRESS <u>5305 Harford Road #14</u>		24a. REG. ANY REGISTRAR <u>JAN 6 '60</u>		24b. REG. STAMP SIGNATURE <u>Arthur S. Trahan</u>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be referred by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending Physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

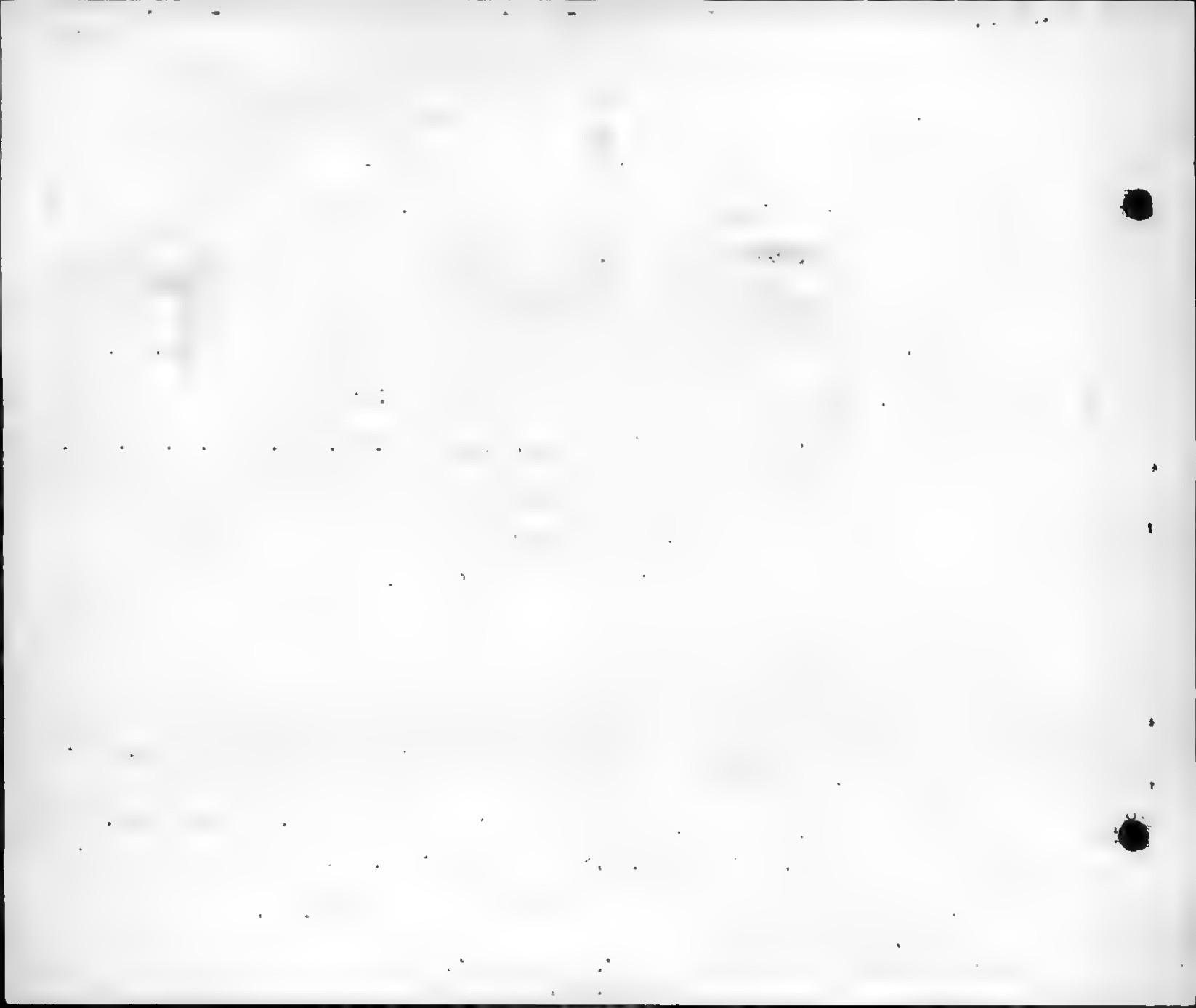
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0325 CERTIFICATE OF DEATH

Reg. Dist. No.

06304

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c LENGTH OF STAY IN lb <b>12 days</b>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>641 S. Avondale Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Alonzo</b>		First <b>D.</b>	Middle <b>Holmes</b>	Last	4. DATE OF DEATH <b>January 17</b>	Month <b>January</b>	Day <b>17</b>	Year <b>1960</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 2, 1886</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City of Baltimore</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>George W. Holmes</b>		14. MOTHER'S MAIDEN NAME <b>Emily O'Neal</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WWI 213-05-6821</b>	INFORMANT <b>Clin. Records, Vet. Adm. Hosp. Balto. Md. Ft. Howard Div.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY EMBOLUS</b>								
INTERVAL BETWEEN ONSET AND DEATH <b>UNK TOWN</b>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>ADENOCARCINOMA PROSTATE</b> (c) <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>								
UNKNOWN								
UNKNOWN								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>January 5, 1960</b> , to <b>January 17, 1960</b> , and that death occurred at <b>7:25 A.M.</b> from the causes and on the date stated above								
ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTIMORE, MD. FT HOWARD DIV. 1/17/60</b> DATE SIGNED								
ACTUAL SIGNATURE <i>Martin Gottlieb</i>								
PHYSICIAN'S NAME (Type) <b>MARTIN W. GOTTLIEB, M.D.</b>		VAH, BALTO. MD. FT HOWARD DIV		1/17/60				
22a. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/26/1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Katie Williams</i>		ADDRESS <b>Katie Williams Funeral Home, 322 S. Schroeder St. Balt. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 20 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>		
VS ATS (4) 15M 9/58								



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0215 CERTIFICATE OF DEATH

Reg. Dist. No.

00365

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied upon by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		<i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <i>364</i>	
<i>Dundalk 22</i>			
d. NAME OF HOSPITAL (If not in Hospital, give street address) OR INSTITUTION <i>307 Avondale Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Dundalk 22</i>	
f. STREET ADDRESS <i>'307 Avondale Road</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH Month Day Year <i>JANUARY 24 1960</i>	
First <i>Lillie</i>		Middle <i>Orarie</i>	
Last <i>Holmes</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>Colored</i>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>JANUARY 21 1905</i>	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
9. AGE (In years lost birthday) <i>55 yrs</i>		10. KIND OF BUSINESS OR INDUSTRY <i>Clothing Co</i>	
11. BIRTHPLACE (State or foreign country) <i>Isle of Wight, Va.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>Clinton Joyner</i>		14. MOTHER'S MAIDEN NAME <i>Rosa E. Saunders</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>915-32-5760</i>	
17. INFORMANT <i>Milton Holmes, 307 Avondale Rd. #22</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>UREMIA</i>			
DUE TO <i>605X</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) <i>CYSTITIS, Nephritis</i>			
DUE TO } (c) <i>CARCINOMA of CERVIX</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>JANUARY 9, 1959</i> , to <i>JANUARY 24, 1960</i> , that I last saw the deceased alive on <i>JANUARY 23, 1960</i> , and that death occurred at <i>6:30 A.M.</i> from the causes and on the date stated above.			
MEDICAL CERTIFICATION ACTUAL SIGNATURE <i>William C. Wade</i>		ADDRESS (Street, city or town, state) <i>140 Oak Avenue, Dundalk 22, Md.</i>	
DATE SIGNED <i>1-24-60</i>			
PHYSICIAN'S NAME (Type) <i>William C. Wade, M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal</i>		22b. DATE THEREOF <i>Jan 26, '60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) <i>Smithfield 22</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Milton E. Eickson 1129 Carter St.</i>		24a. REC'D BY REGISTRAR DATE JAN 27 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Wilma S. Kline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00306

## 0326 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		b. COUNTY <b>BALTO.</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>422 LAMBETH RD</b>		d. STREET ADDRESS <b>1422 LAMBETH RD.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ANNE</b>	Middle <b>WARNER</b>	Last <b>HORSEY</b>
4. DATE OF DEATH	Month <b>JAN.</b>	Day <b>31</b>	Year <b>1960</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 9, 1873</b>
9. AGE (In years lost birthday) <b>86</b> yrs	10. IF UNDER 1 YEAR Months <b>8</b>	11. IF UNDER 24 HRS Days <b>1</b>	12. IF UNDER 24 HRS Hours <b>0</b>
13. CITIZEN OF WHAT COUNTRY: <b>MD.</b>	14. FATHER'S NAME <b>Henry W. Warner</b>		
15. CITIZEN OF WHAT COUNTRY: <b>MD.</b>	16. MOTHER'S MAIDEN NAME <b>Mary Boddy</b>		
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	18. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	19. INFORMANT <b>Mrs. Charles Eustis - 422 Lambeth Rd.</b>	Address
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Dr. Wm. J. O'Brien, Thro. Disease</b>	INTERVAL BETWEEN ONSET AND DEATH <b>1-2-2</b>		
416 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <b>Ch. Rheumatic Heart Disease</b>	DUE TO <b>30-3 (7)</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
21a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
21c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>M.D. 6209 Frederick Ave</b>	21f. (City or town) (County) <b>Baltimore - 28</b>
21. I certify that I attended the deceased from <b>2-16-1940</b> to <b>1-31-1940</b> , that I last saw the deceased alive on <b>1-30-1960</b> , and that death occurred at <b>8:35 P.M.</b> from the causes and on the date stated above			
ACTUAL SIGNATURE <b>Witmer K. Gallagher</b>		ADDRESS (Street, city or town, state) <b>Witmer K. Gallagher</b>	
PHYSICIAN'S NAME (Type)		DATE SIGNED <b>2-2-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2-4-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park Cem.</b>	22d. LOCATION (City, town, or county) <b>Balto</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Fidelity Funeral Home - Catonsville, Md.</b>		24a. ADDRESS <b>Fidelity Funeral Home - Catonsville, Md.</b>	24b. REC'D BY REGISTRAR DATE <b>Feb 5 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Albert S. Knob</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be rated by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



011307

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**032 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		e. STATE Md b. COUNTY					
English Consul				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		51 English Consul		d. STREET ADDRESS					
730 Arbutus Ave		2730 Arbutus Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Samuel	Middle Melvin	Last Howard	4. DATE OF DEATH				
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (in years)				
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 1, 1906	73 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during month of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)					
Plum for		Retired		OHIO					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?					
Unknown Howard		dont know		USA					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT					
No				Mrs. Lillian Howard Address 2730 Arbutus Ave.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 400.1 DUE TO Curiova c. le, interlocutant									
Conditions, if any, which gave rise to immediate (b) DUE TO Curiova c. le, interlocutant									
(a), stating the underlying cause last. (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY		Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
Hour o. m. p. m.		19	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Geo. S. N. Kleffner</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Jan. 26, 1960			
EXAMINER'S NAME (Type)		Geo. S. N. Kleffner, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 29 '60		22c. NAME OF CEMETERY OR CREMATORIAL Sater's Cem.		22d. LOCATION (City, town, or county) Baltimore Co., Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE JOHN F. DENNY, INC. 715 Light St.									
ADDRESS				24a. REC'D BY REGISTRAR DATE JAN 29 '60		24b. REGISTRAR'S SIGNATURE <i>Curtis S. Krause</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificale, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00308

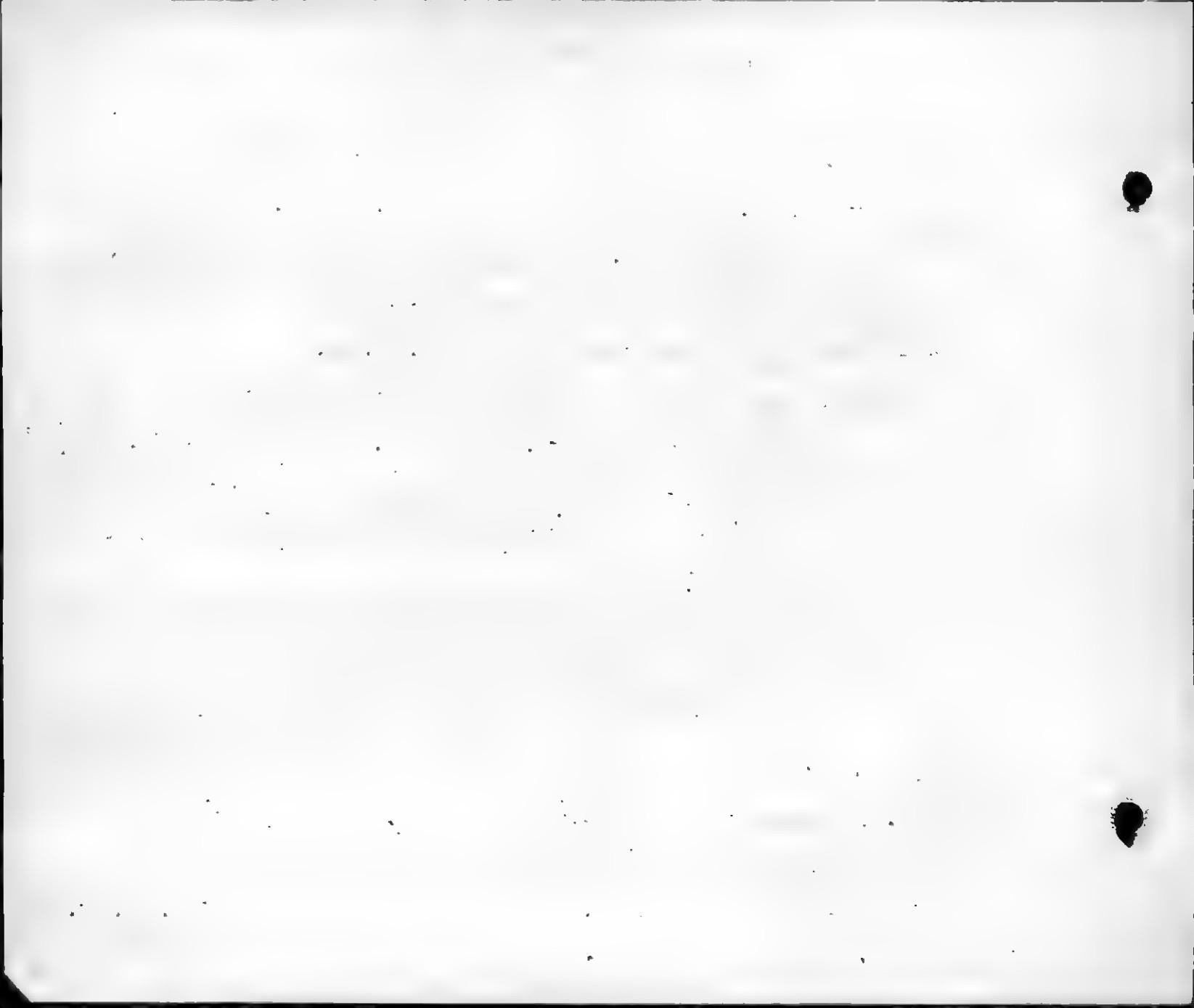
## 0328 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bradshaw</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Reynolds Rd.</b>		e. STREET ADDRESS <b>Reynolds Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>A.</b>	Middle <b>Huber</b>
4. DATE OF DEATH Month <b>January</b>		Day <b>25,</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 4, 1879</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer-Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Roads</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Huber</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Debus</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Katherine V. Chapman Reynolds Rd.</b>		Address <b>Bradshaw, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> 4.1.1.2 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Arteriosclerotic Heart Disease</b> DUE TO <b>Hypertension</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 2, 1948</b> , to <b>Jan 23, 1960</b> , that I last saw the deceased alive on <b>Aug 24, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clifford F. Hudson M.D.</b>		ADDRESS (Street, city or town, state) <b>FORK, MD</b>	
PHYSICIAN'S NAME (Type) <b>CLIFFORD F. HUDSON</b>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Salem Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Upper Falls, Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lauren Funeral Home 7401 Belair Rd.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 27 '60</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 FilmG254 1-8-60 et

00309

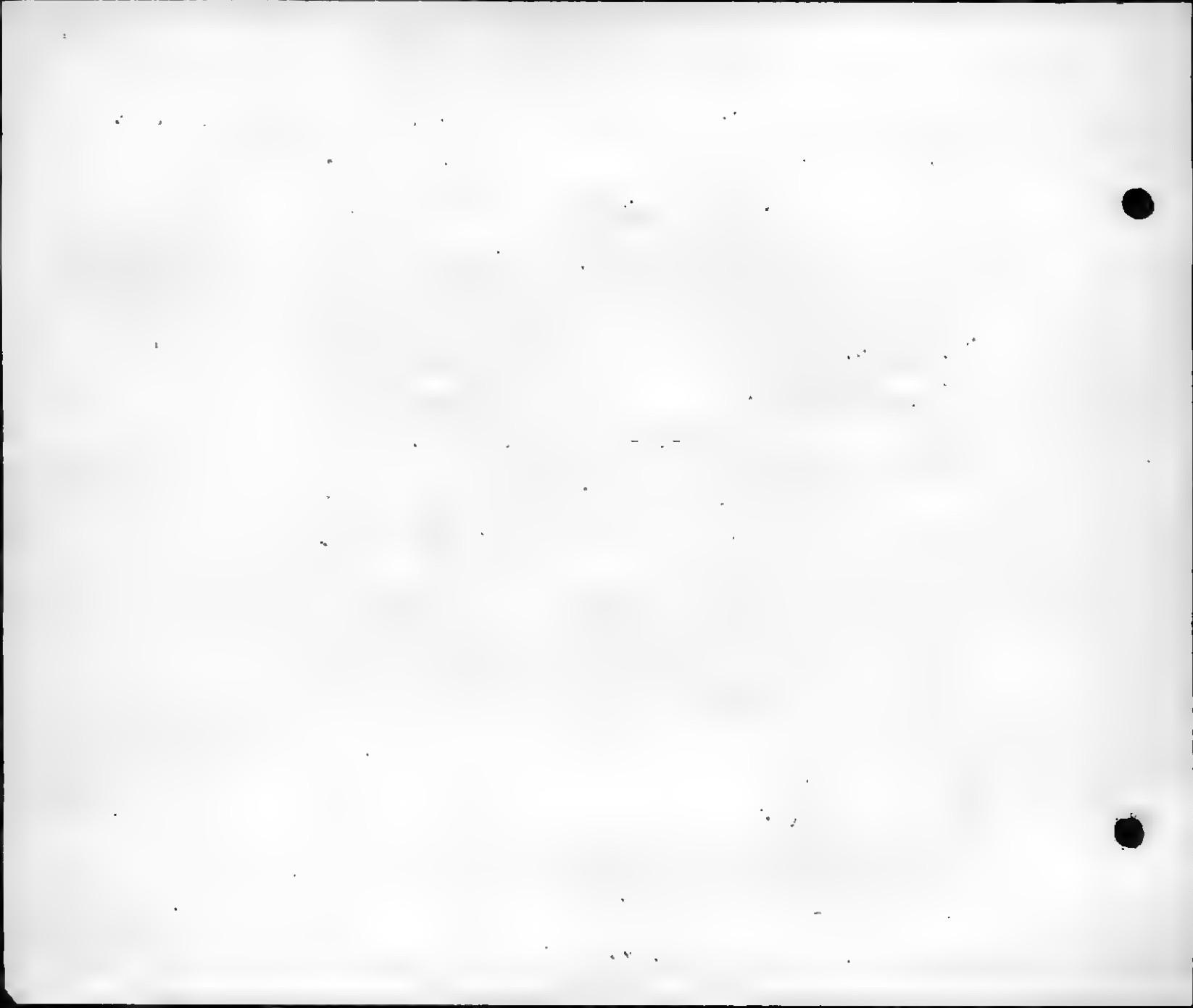
0329

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE	
<i>Baltimore</i> <i>MARYLAND</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Middle River</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>14 Gyro Dr</i>		d. STREET ADDRESS <i>14 Gyro Drive</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Louis</i>	Middle <i>J.</i>	Last <i>Huller</i>
4. DATE OF DEATH	Month <i>Jan</i>	Day <i>2</i>	Year <i>1960</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 15, 1892</i>
9. AGE (In years lost birthday) yrs <i>67</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Martin Co.</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Martin Co.</i>		14. MOTHER'S MAIDEN NAME <i>Mary Anna Klein</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>212-20-6447</i>	INFORMANT <i>Augusta E. Huller</i>
		Address <i>sane</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: (IMMEDIATE CAUSE (a)) <i>Carcin decompensatio, terminal</i>			
4.0.2 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Advanced arteriosclerosis, generalized</i>			
DUE TO DUE TO (c) <i>6 mos.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, <i>JAN</i> , 19 <i>55</i> , to <i>1/1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>12/31</i> , 19 <i>59</i> , and that death occurred at <i>5 P.M.</i> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>1515 - Martin Blvd - Baltimore, Md.</i>	
ACTUAL SIGNATURE <i>Joseph J. Cameron</i>		DATE SIGNED <i>1/4/60</i>	
PHYSICIAN'S NAME (Type) <i>JOSEPH J. Cameron</i>			
22a. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		22b. DATE THEREOF <i>1-6-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parkwood Cemetery</i>
22d. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd</i>		24a. REC'D BY REGISTRAR <i>JAN 5 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Orville L. Trahan</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

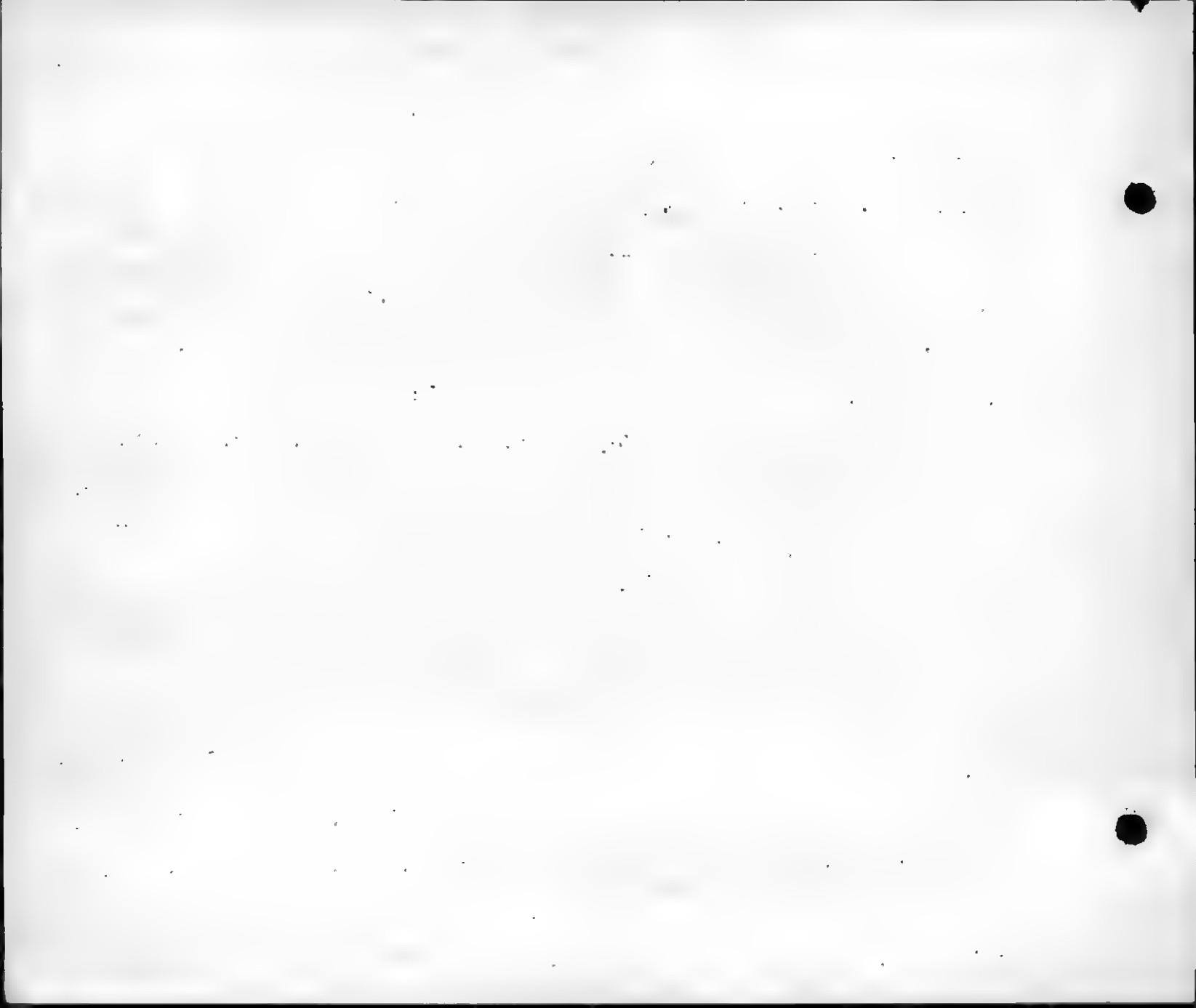
## 0330 CERTIFICATE OF DEATH

Reg. Dist. No. 00310

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>20 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		(5)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>1021 Rutland Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>WILLIAM</b>		First ---	Middle ---	Lost <b>HUTSON</b>	4. DATE OF DEATH <b>January</b>	Month <b>6</b>	Day <b>1960</b>
S SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>February 15, 1892</b>	9. AGE (In years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Moulder</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Foundry</b>		11. BIRTHPLACE (State or foreign country) <b>Georgia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Nelson Hutson</b>				14. MOTHER'S MAIDEN NAME <b>Alice MN: Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>217-03-5013</b>		INFORMANT <b>Clin. Rec., Vet. Adm. Hosp. Balto. 18 Md. Ft. Howard/</b>		Address	Division
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>KIEXO</b> UNKNOWN							
(c) <b>BILATERAL CHRONIC PYELONEPHRITIS</b> UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 17, 1959</b> , to <b>January 6, 1960</b> that I last saw the deceased on <b>18</b> , and that death occurred at <b>1:45 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/7/60</b>							
DATE SIGNED							
ACTUAL SIGNATURE <b>John W. Crawford</b>							
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>							
VAH, BALTO. 18, MD. FT. HOWARD DIV. 1/7/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips 1808 N. Monroe St., Balto.</b>							
ADDRESS <b>17, Md.</b>				24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>		24b. REGISTRAR'S SIGNATURE <b>John E. Tracy</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0331 CERTIFICATE OF DEATH

Reg. Dist. No. 00311

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE						
Baltimore		Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	b. COUNTY						
		Maryland						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
7312 Dogwood Road	7312 Dogwood Road							
3. NAME OF DECEASED (Type or print)	First RICHARD	Middle MORAN	Last IRELAND	4. DATE OF DEATH	Month January	Day 18	Year 19 60	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	July 9, 1885	74 yrs.	Months	Days	Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
Carpenter		Retired		Carroll Co., Maryland		USA		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
No		216-01-3675		Elizabeth Ireland-7312 Dogwood Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)								
157X DUE TO <i>Andigo - Respiratory failure</i>								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO <i>Polyhydratid &amp; malnutrition</i>								
(c) <i>Carcinoma of pancreas</i>								
INTERVAL BETWEEN ONSET AND DEATH								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)								
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County)	(State)	
21. I certify that I attended the deceased from <u>Sept</u> , 19 <u>59</u> , to <u>18 Jan</u> , 19 <u>60</u> that I last saw the deceased alive on <u>18 Jan</u> , 19 <u>60</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>William J. Bryson M.D. 4605 Edmondson Ave.</i>							DATE SIGNED <i>19 Jan 60</i>	
ACTUAL SIGNATURE <i>William J. Bryson</i>		PHYSICIAN'S NAME (Type) William J. Bryson, M.D.		4605 Edmondson Ave., -				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/1960		22c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Cemetery		22d. LOCATION (City, town, or county) Baltimore		(State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmerith</i>		ADDRESS 4600 Liberty Heights Ave.		24a. REC'D BY REGISTRAR DATE JAN 21 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>		



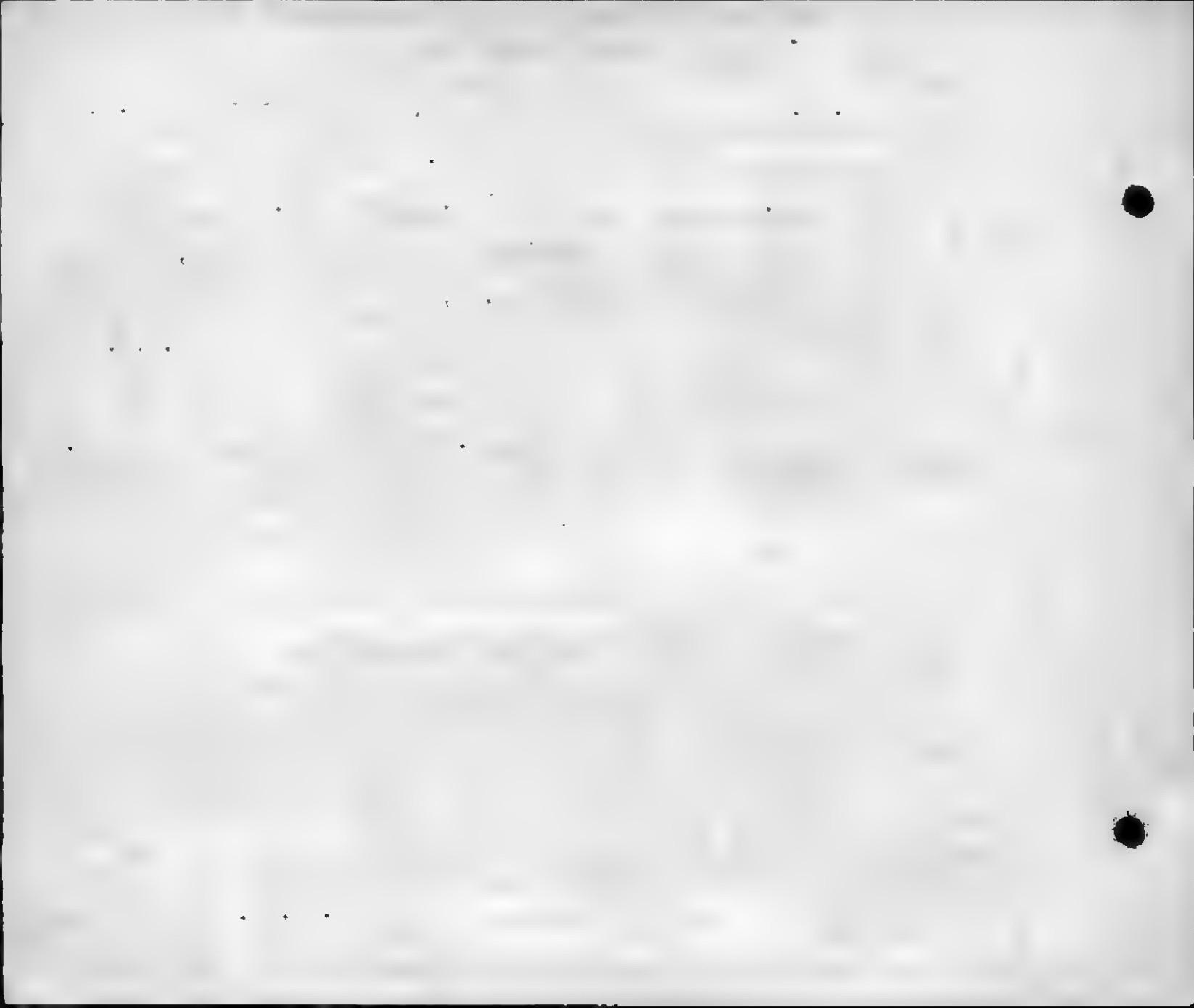
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0332 CERTIFICATE OF DEATH

Reg. Dist. No.

00312

1. PLACE OF DEATH a. COUNTY <b>Balto. Co.</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>		c. LENGTH OF STAY IN 1b <b>4 Months</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8102 Rosebank Ave. (Private home)</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balto. City</b>		
3. NAME OF DECEASED (Type or print) <b>Lena</b>		First <b>Lena</b>	Middle <b>Jankiewicz</b>	
Last <b>Jankiewicz</b>		4. DATE OF DEATH <b>January 11,</b>	Month <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Sept. 29, 1878</b>	
		DIVORCED <input type="checkbox"/>	9. AGE (In years (at birthday) yrs <b>81</b> )	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Poland</b>	
		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Wojciech Spioch</b>		14. MOTHER'S MAIDEN NAME <b>Justina Jacinty</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO <b>None</b>	17. INFORMANT Address <b>Joseph A. Jankiewicz 1713 Eastern Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Cecum &amp; Metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos.</i>		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour p. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>6370 Balt. Rd.</i>	(County) <i>Balto. Co.</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Aug. 1959</i> to <i>Jan. 11, 1960</i> that I last saw the deceased alive on <i>Jan. 11, 1960</i> , and that death occurred at <i>6370 Balt. Rd.</i> M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>2002 6 Balt. Rd. Balt. Md.</i>		
ACTUAL SIGNATURE <i>Isreal J. Feinglos</i>	PHYSICIAN'S NAME (Type) <i>ISRAEL J. FEINGLOS</i>	DATE SIGNED <i>1/13/60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/15/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Holy Rosary</b>	22d. LOCATION (City, town, or county) <b>Balto. Co. Md.</b>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. S. Fialkowski 2007 Eastern Ave.</i>		ADDRESS	24a. REC'D BY REGISTRAR <b>DATE JAN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Wm. S. Fialkowski</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0219 CERTIFICATE OF DEATH

Reg. Dist. No.

00313

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Dundalk				53 Dundalk 22				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		7822 St. Fabians Lane		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First William	Middle Louis	Last Jenkins	4. DATE OF DEATH	Month January	Day 7	Year 1960

S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 13, 1894	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker	10b. KIND OF BUSINESS OR INDUSTRY Cross & Blackwell	11. BIRTHPLACE (State or foreign country) Baltimore	12. CITIZEN OF WHAT COUNTRY? U.S.A.
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13. FATHER'S NAME William E. Jenkins	14. MOTHER'S MAIDEN NAME Mary Wright
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES	16. SOCIAL SECURITY NO. W W I 217-05-5525	17. INFORMANT Mrs. Pearl M. Jenkins, 7822 St. Fabains Lane	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Primary Cause was of lung</i>	INTERVAL BETWEEN ONSET AND DEATH 2 mos -
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	

MEDICAL CERTIFICATION	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	

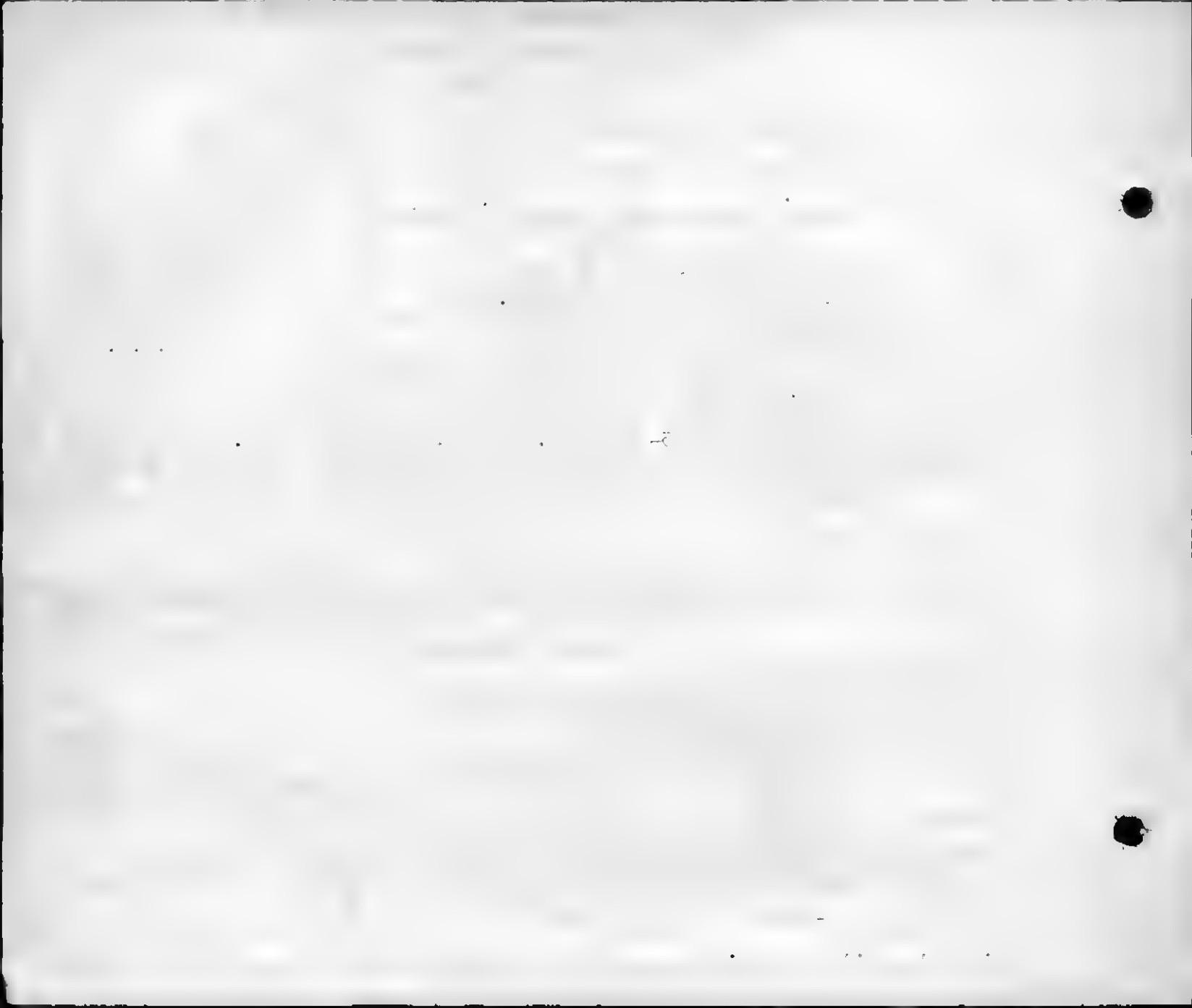
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I attended the deceased from <i>Aug. 29, 1959</i> , to <i>Jan. 7, 1960</i> , that I last saw the deceased alive on <i>Jan. 7, 1960</i> , and that death occurred at <i>3:35 P.M.</i> , from the causes and on the date stated above.	ADDRESS (Street, city or town, state)	DATE SIGNED
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ACTUAL SIGNATURE <i>Manuel P. de Leon</i>	M.D.	
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PHYSICIAN'S NAME (Type)	MANUEL P. DE LEON	Baltimore 24, Maryland.
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22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 1-11-60	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore National	22d. LOCATION (City, town, or county) Baltimore	(State)
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook, Inc., 1217 St. Paul Street	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 11 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reported by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

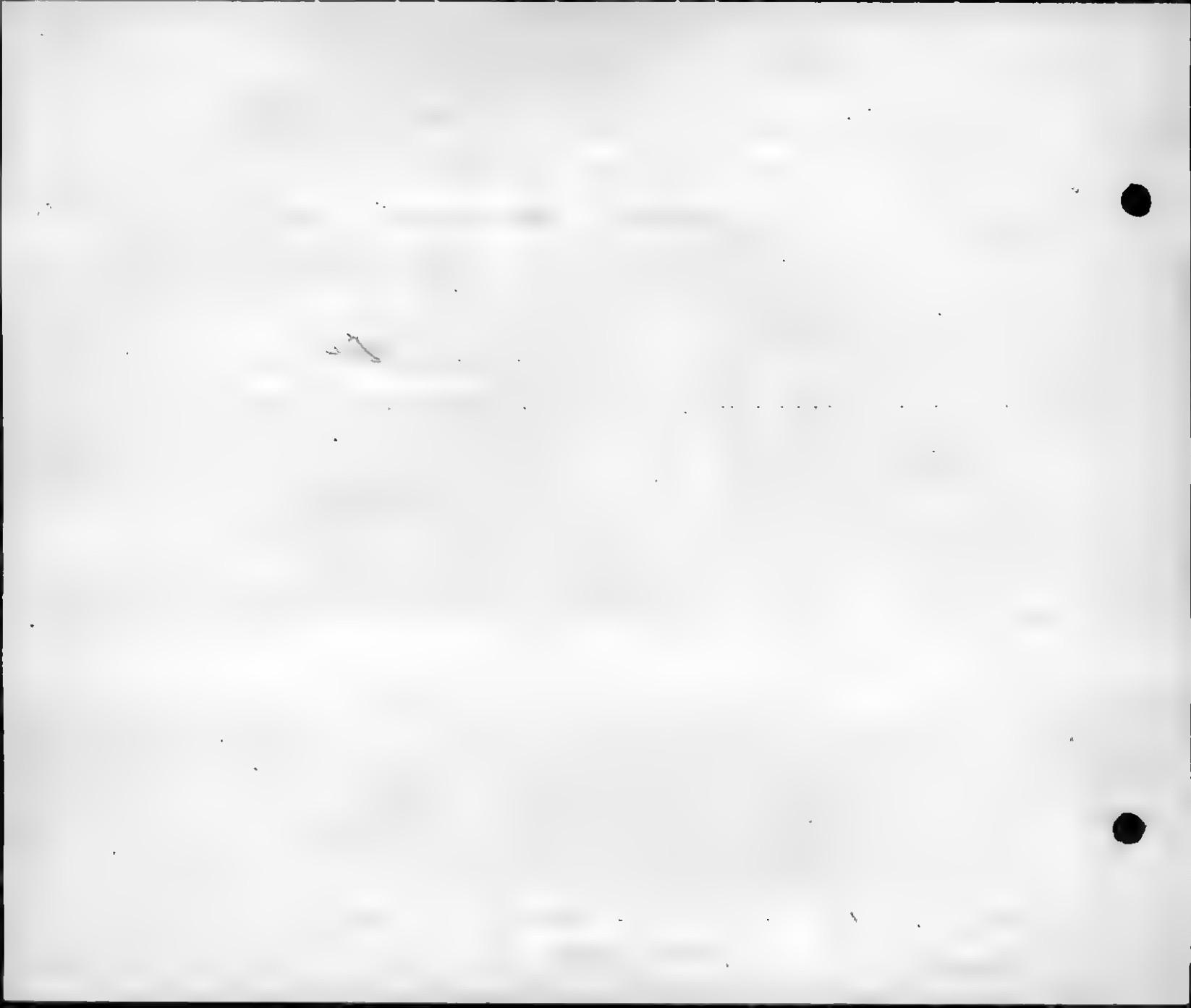
## CERTIFICATE OF DEATH

00314

0333

Item 2 Form 254 1-2-60

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <i>Penn.</i> b. COUNTY <i>Baltimore</i> ?	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colonsville</i>		c. LENGTH OF STAY IN 1b <i>8 yrs.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Summit Lour. Home</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Guthrieville</i> New Freedom	
3. NAME OF DECEASED (Type or print) <i>Joy Jones</i>		First <i>Joy</i>	Middle <i>Jones</i>
4. SEX <i>Female</i>	5. COLOR OR RACE <i>White</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	7. DATE OF BIRTH <i>5/8/70</i>
8. DATE OF DEATH <i>Jan 14</i>		9. AGE (in years last birthday) <i>89 yrs</i>	10. IF UNDER 1 YEAR Months <i>1600</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>	11. BIRTHPLACE (State or foreign country) <i>Freeland Md.</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Edward Winchelt</i>	14. MOTHER'S MAIDEN NAME <i>Amanda Keeney</i>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Hospital records</i>	17. INFORMANT <i>Address</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Congestive Heart Failure</i>			
DUE TO (c) <i>Generalized Arterio sclerosis.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1955</i>
20f. (City or town) <i>1114/60</i>		(County) <i>19</i>	
(State) <i>19</i>			
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____, and that death occurred _____, from the causes and on the date stated above			
22a. SIGNATURE <i>W.E. McGrath M.D.</i>			
22b. DATE SIGNED <i>1/14/60</i>			
22c. PHYSICIAN'S NAME (Type) <i>W.E. McGrath M.D.</i>		22d. ADDRESS <i>1303 Frederick Rd (28)</i>	
23a. BURIAL, CREMATION OR REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Jan 18 1960</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Stitt Cemetery</i>
23d. LOCATION (City, town, or county) <i>Glen Rock Pa. R.D.3.</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>S Jacob Hirschstein</i>		25a. ADDRESS <i>New Freedom, Pa.</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur S. Head</i>
25c. DATE <i>Jan 19 60</i>		25d. DATE <i>Jan 19 60</i>	



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00315

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sparrows Point, Md.		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sparrows Point, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bethlehem Steel Hospital		d. STREET ADDRESS 1005 "K" St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Eddic		First	Middle (n)	Last Jordan	4. DATE OF DEATH January	Month 26	Year 1960
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Unknown	9. AGE (In years last birthday) 61 yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Skill Laborer		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Smithfield Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John E. Jordan		14. MOTHER'S MAIDEN NAME Mamie Holloway					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-09-2571		17. INFORMANT Frank Jordan 1523 McKeen Ave		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lawyer due to Heart Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. DUE TO (c) Hypertension due to cerebral vascular disease.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Jack C. Collins</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1-26-60	
EXAMINER'S NAME (Type) / JACK C. Collins		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL CREMATION: REMOVAL (Specify) Burial		22b. DATE THEREOF 2/1/60		22c. NAME OF CEMETERY OR CREMATORIAL Gable** Gamble Chapel		22d. LOCATION (City, town, or county) Smithfield Virginia (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Eugene Wilson 1000 Brantley Ave</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE 29 1960		24b. REGISTRAR'S SIGNATURE <i>Eugene S. Thomas</i>	

**NOTICE** MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Farm PHM. Page 5 may be retained by your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0335

## CERTIFICATE OF DEATH

Reg. Dist. No.

00316  
32

1. PLACE OF DEATH a. COUNTY Baltimore County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY BALTO. CITY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		c. LENGTH OF STAY IN 16 1 1/2 yrs - 05		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE CITY		d. STREET ADDRESS 3112 E. MONUMENT STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First GEORGE	Middle WALTER	Last JURKOWSKI	4. DATE OF DEATH 1960	Month JANUARY	Day 3	Year 1960
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/25/17		9. AGE (In years last birthday) 42 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TREK DRIVER		10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME FRANK JURKOWSKI		14. MOTHER'S MAIDEN NAME MARGARET PRECHTEL						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-03-2040		17. INFORMANT Hospital Records, Mt. Wilson State Hospital		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		PULMONARY TUBERCULOSIS				INTERVAL BETWEEN ONSET AND DEATH 24 YEARS		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b)						
DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Mt. Wilson, Maryland		(County) (State)
21. I certify that I attended the deceased from 6/24, 1958, to 1-3, 1966, that I last saw the deceased alive on 1-3, 1966, and that death occurred at Mt. Wilson, M.D., from the causes and on the date stated above. ACTUAL SIGNATURE				ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type)		William Newcomer, M.D.		Superintendent				
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1-7-60.		22c. NAME OF CEMETERY OR CREMATORIUM ST. STANISLAUS CEM		22d. LOCATION (City, town, or county) 6515 BOSTON ST. BALTO. MD.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Charles S. Geiter		ADDRESS 901 S. CONKLING ST. BALTO. MD.		24a. REC'D BY REGISTRAR Jan 8 60		24b. REGISTRAR'S SIGNATURE Charles S. Geiter		
				DATE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No.

00317

1. PLACE OF DEATH a. COUNTY	0338 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Towson	50 yrs	Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	d. STREET ADDRESS 6402 Pratt Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Frances	Middle D.	Last Kahler	4. DATE OF DEATH Jan. 8, 1960
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5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Mar. 1, 1869	9. AGE (in years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
WIDOWED <input checked="" type="checkbox"/>		DIVORCED <input type="checkbox"/>				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) York, Penna.	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME Henry Weaver	14. MOTHER'S MAIDEN NAME Matilda Schroeder
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Mr. J. C. Anderson 6402 Pratt Ave Baltimore, Md.
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) DUE TO (c)	Coronary calcification with stroke	INTERVAL BETWEEN ONSET AND DEATH Address
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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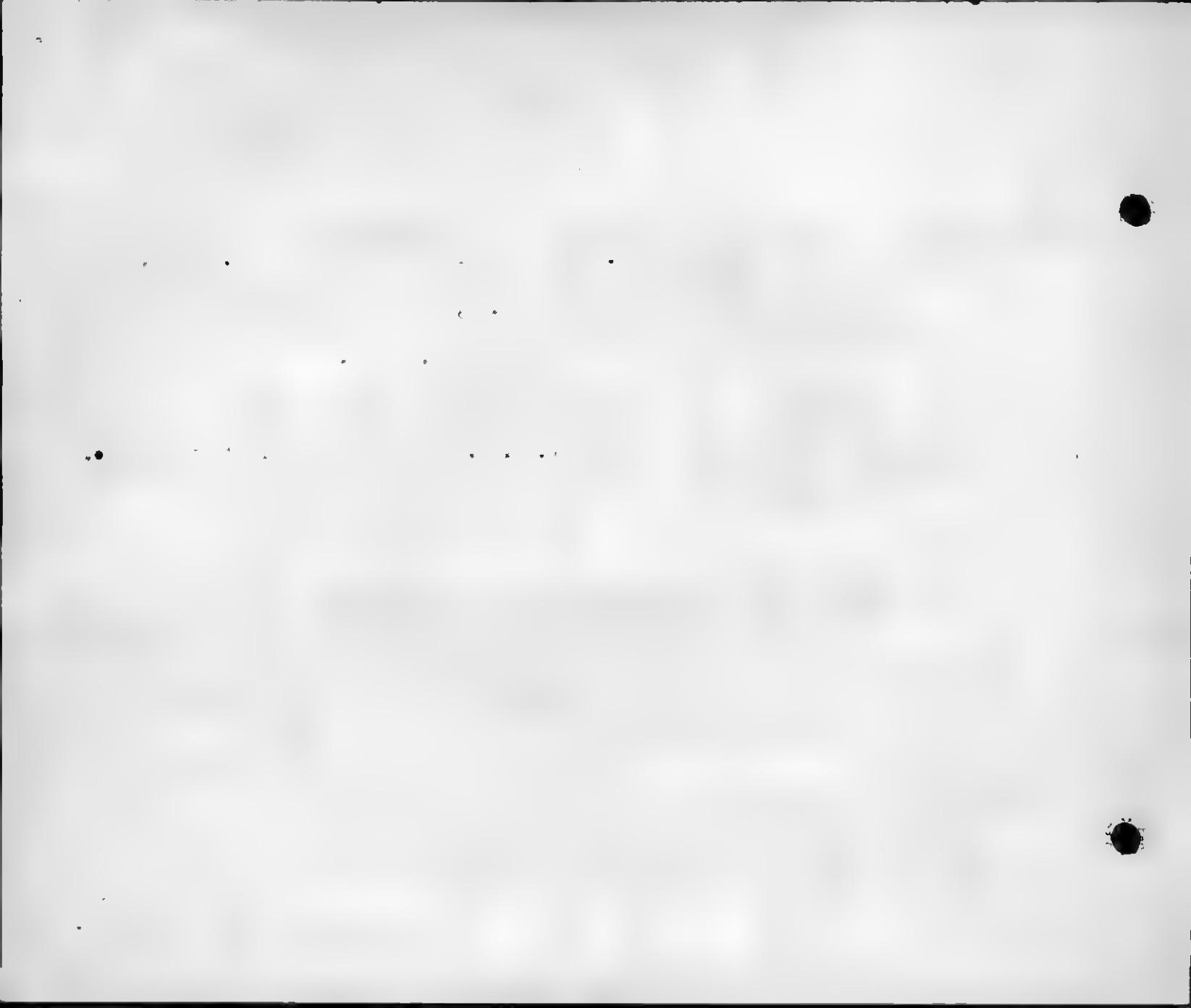
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
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20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .
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ACTUAL SIGNATURE <i>Charles J. Anderson</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1/8/66
EXAMINER'S NAME (Type) <i>Charles J. Anderson</i>		

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/11/60	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland.
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. W. Tolman &amp; Sons, Inc., Balt. Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR JAN 11 1960	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Dunn</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

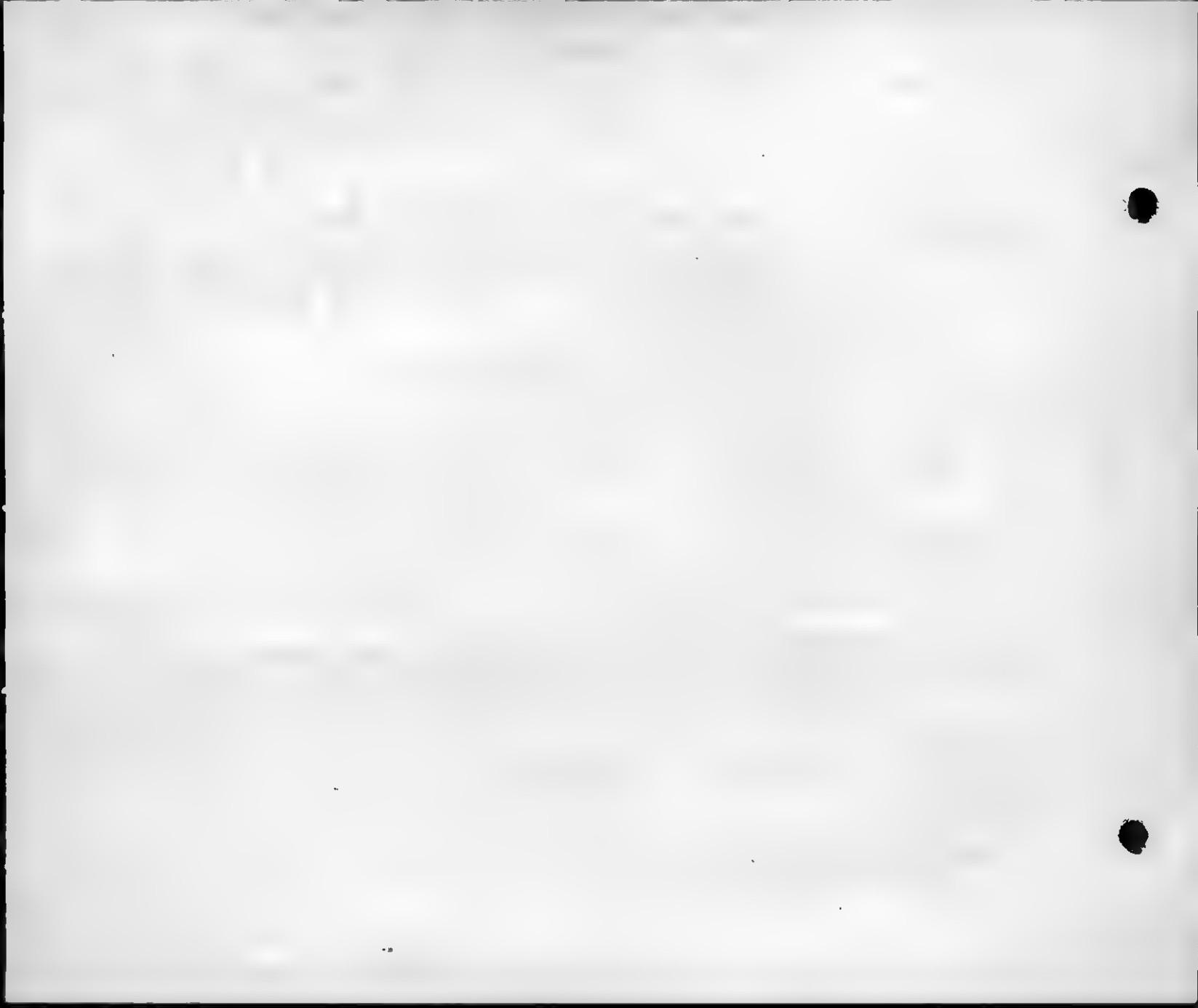
Item 9 r/r 1957 2-8-60 et

00318

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <del>Baltimore</del>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Towson		c. LENGTH OF STAY IN 1b X Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Glenarm Road		e. STREET ADDRESS Glenarm Road	
3. NAME OF DECEASED (Type or print) Sister Mary Constantine Kirchner		4. DATE OF DEATH January 31 1960	5. SEX Female
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH October 19, 1884
9. AGE (In years last birthday) 75 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	11. KIND OF BUSINESS OR INDUSTRY Baltimore Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Michael Kirchner	
14. MOTHER'S MAIDEN NAME Cunigunda Loeffler		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Sister A. Peter Fourier Notch Cliff, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Hypertensive Cardio- Renal Vascular disease (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, at _____, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Charles F. O'Donnell</i> PHYSICIAN'S NAME (Type) Charles F. O'Donnell M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2-2-60	
22c. NAME OF CEMETERY OR CREMATORIAL VILLA MARIA CEM N'OTCH CLIFF NR TOWSON, MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Charles F. O'Donnell</i>		ADDRESS 901 S. CONKLING ST. BALTO, MD.	
		24a. REC'D BY REGISTRAR FEB 2 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

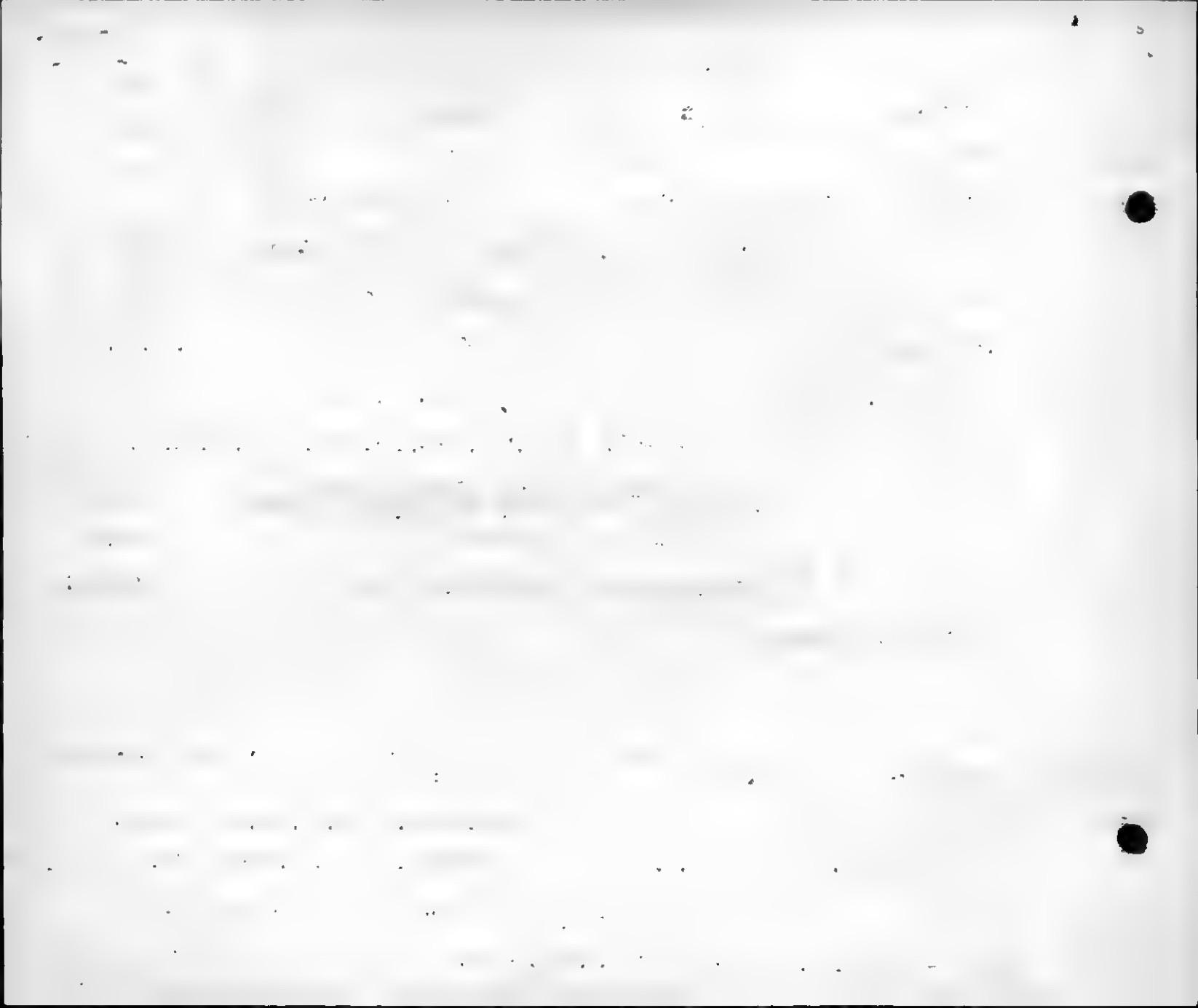


## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0338 CERTIFICATE OF DEATH

Reg. Dist. No. 00319

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>39 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> (1) <b>343</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>3 West Preston Street</b>	
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>E.</b>	Last <b>KNABE</b>	4. DATE OF DEATH <b>January</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>February 2, 1925</b>	Month <b>January</b>
8. AGE (In years last birthday) <b>34</b>		9. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Taxi Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>William E. Knabe</b>		14. MOTHER'S MAIDEN NAME <b>Emma P. Eisenlehr</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-12-0654</b>		INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ACUTE CEREBRAL INFARCT, RIGHT HEMISPHERE</b> DUE TO <b>THROMBOSIS OF RIGHT INTERNAL CAROTIC ARTERY</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>OLD MYOCARDIAL INFARCTION</b> (c) <b>GENERALIZED ARTERIOSCLEROSIS, MARKED</b>				2 DAYS	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION NAMED IN PART 1(a) <b>Multiple Sclerosis</b>		UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 4, 1959</b> , to <b>January 12, 1960</b> , and that death occurred at <b>5:45 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>John E. Crawford</i>				ADDRESS (Street, city or town, state) M.D. <b>VAH, Balto. 18, Md. Ft. Howard Division 1/13/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-15-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm Cook-Bright, Inc. 6009 Harford Rd.</i>		ADDRESS <i>Wm Cook-Bright, Inc. 6009 Harford Rd. Balto. 14, Md.</i>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
				(State)	
				24a. REC'D BY REGISTRAR DATE JAN 19 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kimes</i>	



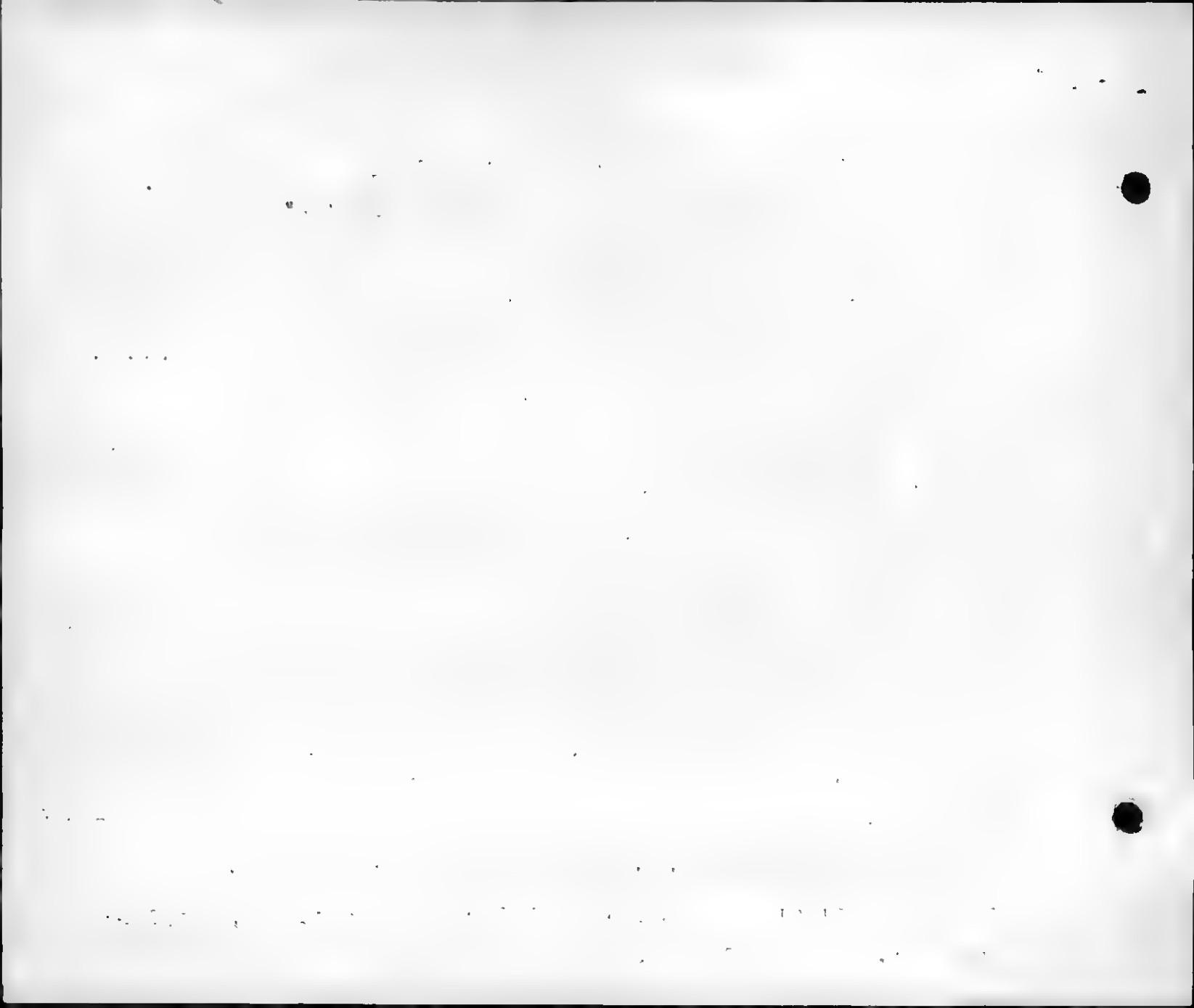
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00320

## 0339 CERTIFICATE OF DEATH

Reg. Dist. No.

1		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.	
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.			
1		1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND	
2		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
3		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
4		c. LENGTH OF STAY IN 1b lyr 7mth 2dys	
5		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL	
6		3. NAME OF DECEASED (Type or print) Essa First; June Middle; Knauff Last	
7		4. DATE OF DEATH JANUARY 19 1960	
8		5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> June 18, 1881 9. AGE (In years last birthday) 78 yrs	
10		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 10b. KIND OF BUSINESS OR INDUSTRY sewing factory 11. BIRTHPLACE (State or foreign country) Maryland	
12		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13		13. FATHER'S NAME Milton Lewis Belleson 14. MOTHER'S MAIDEN NAME CLARISSA Glarine Willis	
15		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO 213-20-6820 17. INFORMATION Address Records: SPRING GROVE STATE HOSPITAL	
18		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Terminal pneumonia INTERVAL BETWEEN ONSET AND DEATH	
19		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease (c)	
20		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
22		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
23		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
24		21. I certify that I attended the deceased from Jan. 7, 1960, to Jan. 19, 1960, that I last saw the deceased alive on Jan. 19, 1960, and that death occurred at 8:15 pm, from the causes and on the date stated above. ADDRESS (Street, city or town, state)	
25		ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 1-19-60	
26		PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland	
27		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 1-22-60 22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery 22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
28		23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard 4107 Wilkens Avenue ADDRESS 24a. REC'D BY REGISTRAR DATE JAN 22 '60 24b. REGISTRAR'S SIGNATURE Colleen L. Kraus	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Form 255 2-1-60 et

035

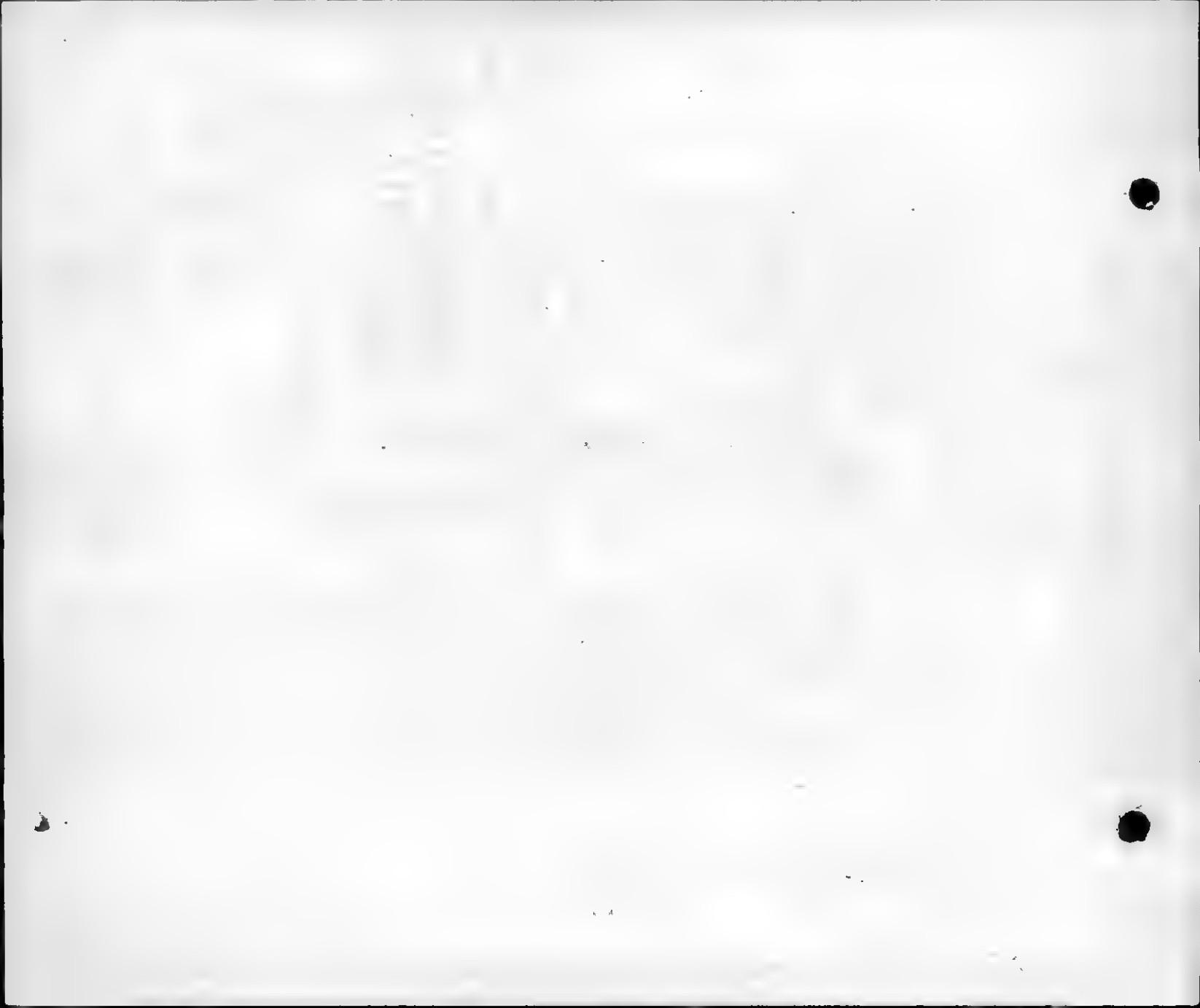
## CERTIFICATE OF DEATH

Reg. Dist. No.

00321

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE b. COUNTY	
<b>BALTIMORE</b> MARYLAND		<b>MARYLAND BALTO.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<b>STONELEIGH</b>		<b>X STONELEIGH</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
<b>6901 MARLBOROUGH, RD.</b>	<b>16901 Marlborough, Rd.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
<b>WALTER</b>			<b>A. KOLPACK</b>
4. DATE OF DEATH	Month	Day	Year
<b>JAN 2 1959</b>			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
<b>MALE</b>	<b>WHITE</b>	<b>Married</b>	<b>AUG. 20, 1889</b>
9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country)
70 yrs.	<b>AUTO DEALER</b>	<b>RETIRED</b>	<b>HOWARD. CO.</b>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
<b>FRANK KOLPACK</b>	<b>Reng.</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	INFORMANT	Address
<b>NO</b>	<b>219-28-4061</b>	<b>MRS LOTTIE C. KOLPACK.</b>	<b>SAME.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)			
<b>420.1</b>			
DUE TO			
Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
Arteriosclerosis			
DUE TO			
10 years			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 1959</b> to <b>2 Jan 1960</b> that I last saw the deceased alive on <b>2 Jan 1960</b> , and that death occurred at <b>1030 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Charles H. Reier</b> ADDRESS (Street, city or town, state) <b>6701 York Rd Baltimore Maryland</b> DATE-SIGNED <b>4 Jan 60</b>			
PHYSICIAN'S NAME (Type) <b>Charles H. Reier</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM	22d. LOCATION (City, town, or county) (State)
<b>BURIAL</b>	<b>1-6-60</b>	<b>WESTERN CEMETERY</b>	<b>BALTIMORE MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS	24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<b>HENRY W. JENKINS &amp; Sons Co.</b>	<b>4905 YORK, RD.</b>	<b>JAN 6 '60</b>	<b>Arthur S. Thomas</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0341

## CERTIFICATE OF DEATH

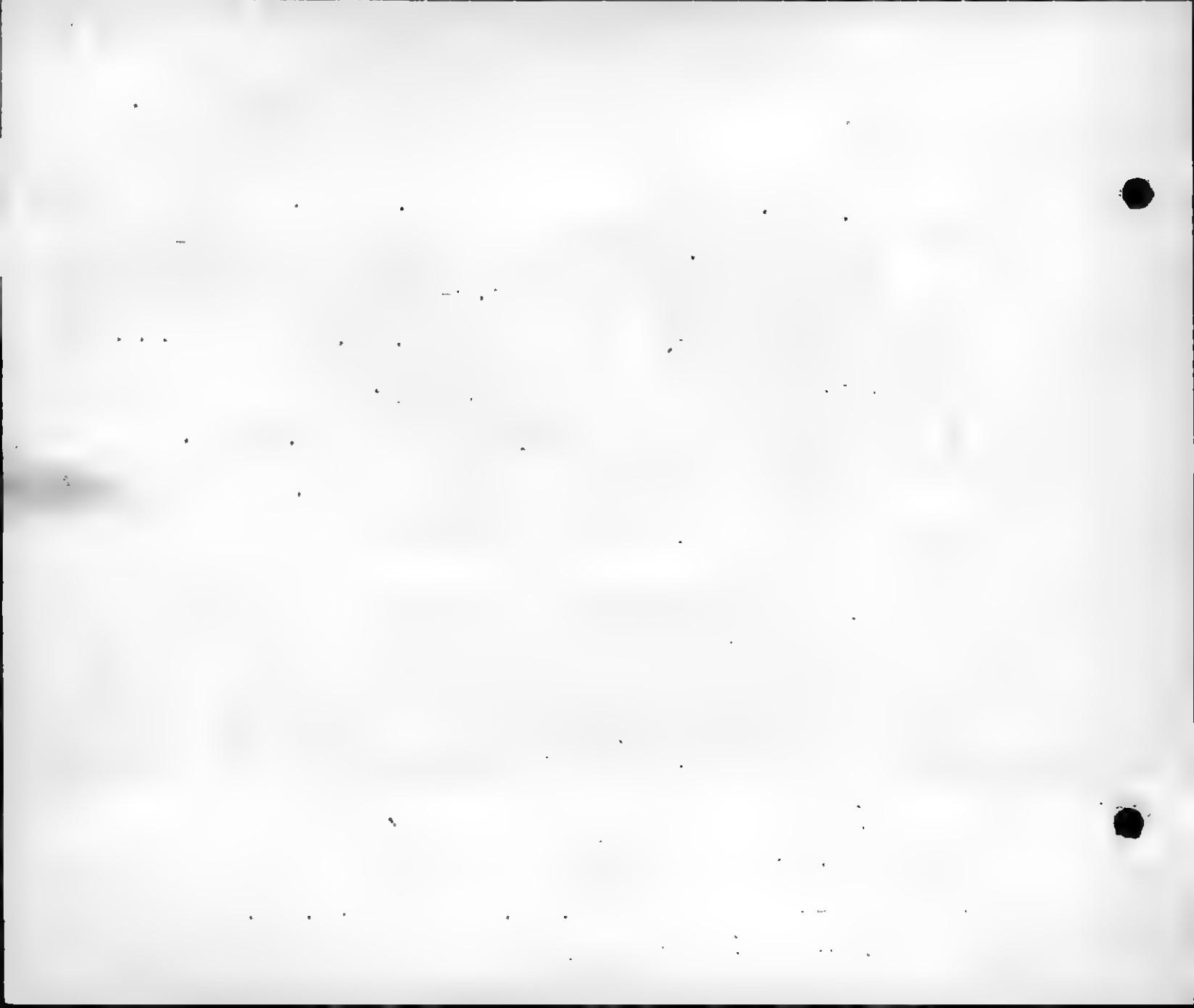
Reg. Dist. No.

00322

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Overlea</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>101 W. Elm Ave</b>				d. STREET ADDRESS <b>101 W. Elm Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Margaret</b>	Middle <b>R.</b>	Last <b>Kornmann</b>	4. DATE OF DEATH Month <b>January</b>	Year <b>31-1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 3-1886</b>	9. AGE (in years last birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Balto., Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Norris</b>		14. MOTHER'S MAIDEN NAME <b>Rose Worth</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		INFORMANT <b>Melvin Kornmann 101 W. Elm Ave.</b>	
17. MEDICAL CERTIFICATION					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cardio vascular Disease (c) DUE TO Hyper tension Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH undet			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypo thyroidism</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Young</b> , 19 <b>57</b> , to <b>Jan 31, 1960</b> , that I last saw the deceased alive on <b>28 Jan</b> , 19 <b>60</b> , and that death occurred at <b>4:5 AM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>John C. Hyde</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>7527 Belair Rd 2-2-60</b>			
PHYSICIAN'S NAME (Type) <b>JOHN C. HYDE</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Pk. Cem.</b>	
22d. LOCATION (City, town or county) <b>Balto., Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Bellard</b>		ADDRESS <b>7481 Bellard St.</b>		24a. REC'D BY REGISTRAR DATE <b>3 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Knapp</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

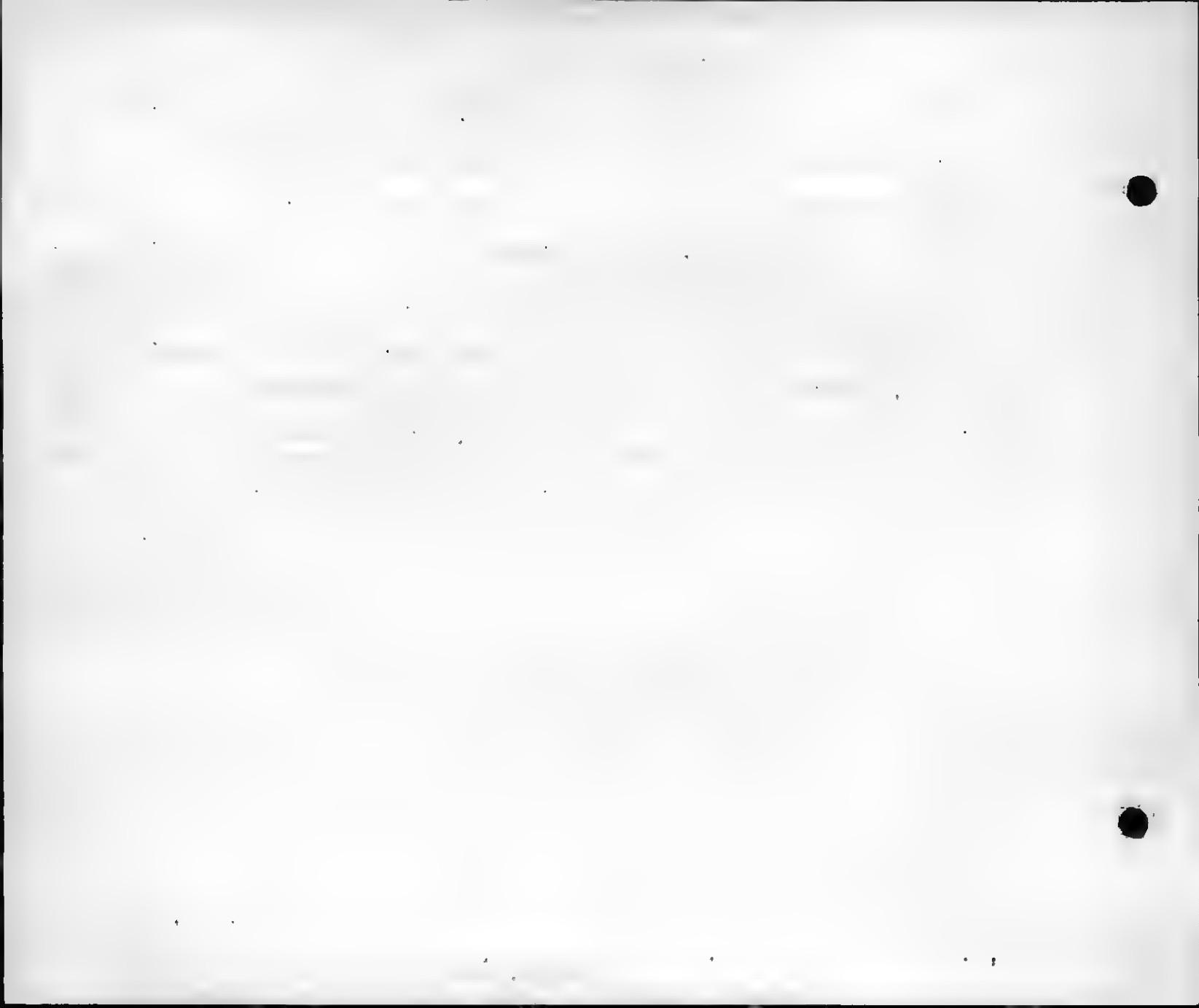
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0342 CERTIFICATE OF DEATH

Reg. Dist. No.

00323

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural (Baltimore)</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural (Baltimore )</b>		d. STREET ADDRESS <b>304 Overbrook Road</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>304 Overbrook Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Ida M. Krause</b>		First	Middle	Last	4. DATE OF DEATH <b>1 25 19 60</b>	Month	Day	Year
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/27/1881</b>	9. AGE (In years last birthday) <b>78 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or Foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>John J. Krause</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Unkelbach</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO		INFORMANT <b>Mabel E. Krause (Abbe)</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>								
420.1 DUE TO (b) <b>ARTERIOSCLEROSIS</b> 8 yrs								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). DUE TO (c) <b>DIABETES MELLITUS</b> 6 yrs.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
NONE								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>NONE</b>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I attended the deceased from <b>Dec 29, 19 59</b> , to <b>Jan 26, 19 60</b> , that I last saw the deceased alive on <b>Jan 26, 19 60</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <b>6710 York Rd</b> DATE SIGNED <b>1/27/60</b>								
ACTUAL SIGNATURE <b>A.S. Chalfant</b>		M.D.						
PHYSICIAN'S NAME (Type) <b>Dr. A.S. CHALFANT</b>		Baltimore, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/28/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co. - 4905 York Rd.</b>		ADDRESS <b>Baltimore, Md.</b> REC'D BY REGISTRAR DATE <b>JAN 27 '60</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>						



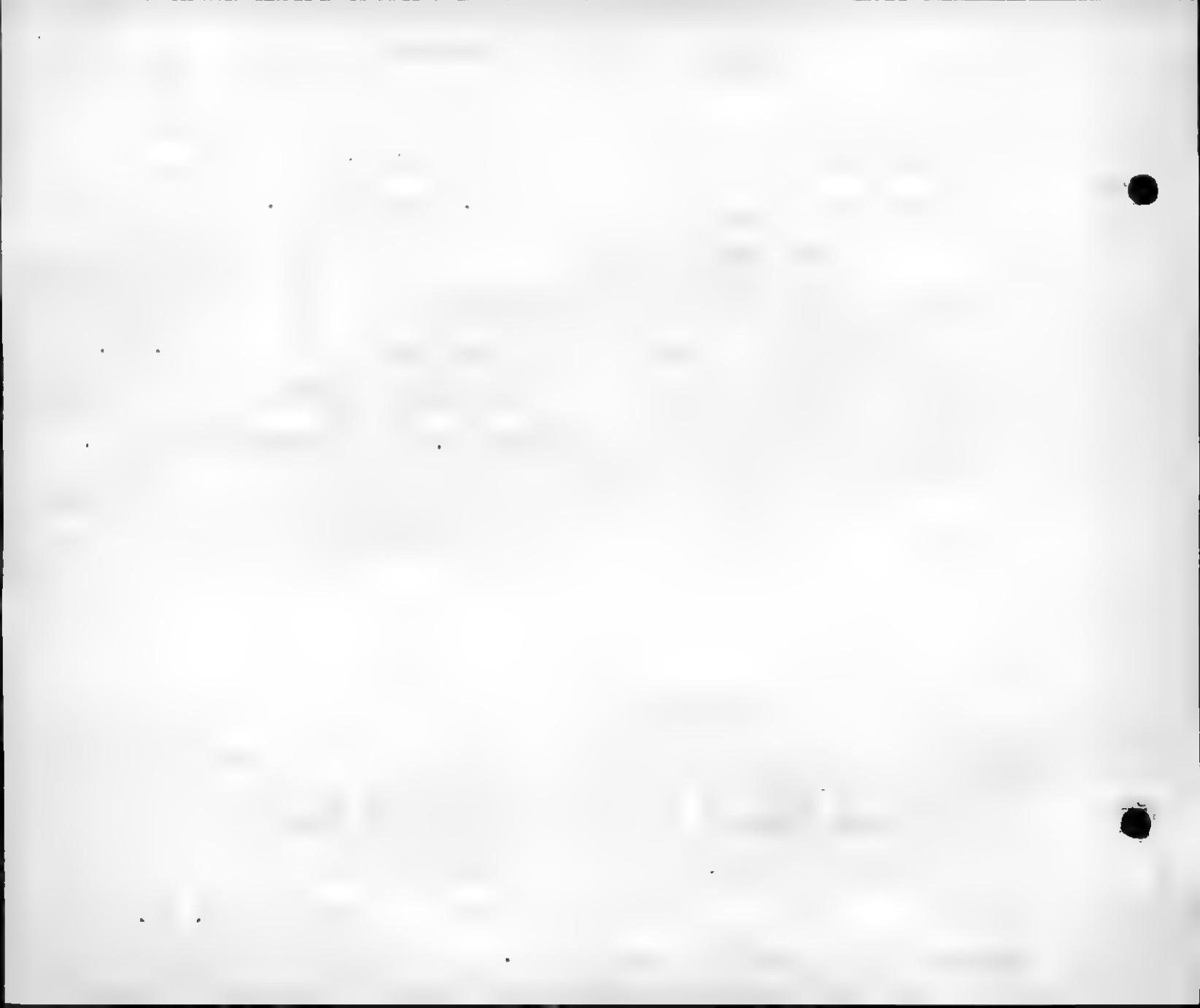
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

110324

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN lb <b>??</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>22 N. Ashburton St.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Warren Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <b>Amelia Hess Krout</b>		First	Middle	Last	4. DATE OF DEATH <b>1-27-60</b>	Month	Day	Year
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH <b>8-4-1870</b>	9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>Henry Hess</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Leister</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		INFORMANT <b>Russell I. Krout, Cockeysville, Md.</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Carcinoma Lt. Breast (c)						INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b>		
						<b>3 yrs.</b>		
19. MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from _____, 19 <b>38</b> , to <b>1-27-</b> , 19 <b>60</b> that I last saw the deceased alive on <b>1-27-1960</b> , and that death occurred at <b>3 P.M.</b> from the causes and on the date stated above.								
ACTUAL SIGNATURE <b>P. H. Siret</b>						ADDRESS (Street, city or town, state) <b>3105 1/2 Charles St.</b>		
PHYSICIAN'S NAME (Type) <b>P. H. Siret</b>						DATE SIGNED <b>Baltimore, 18. 1/60.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-30-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sherwood Episcopal</b>		22d. LOCATION (City, town, or county) <b>Cockeysville, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>		ADDRESS		24a. REGISTRY REGISTRAR <b>FEB 1 1960</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Kline</b>		
				DATE				



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in b.,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

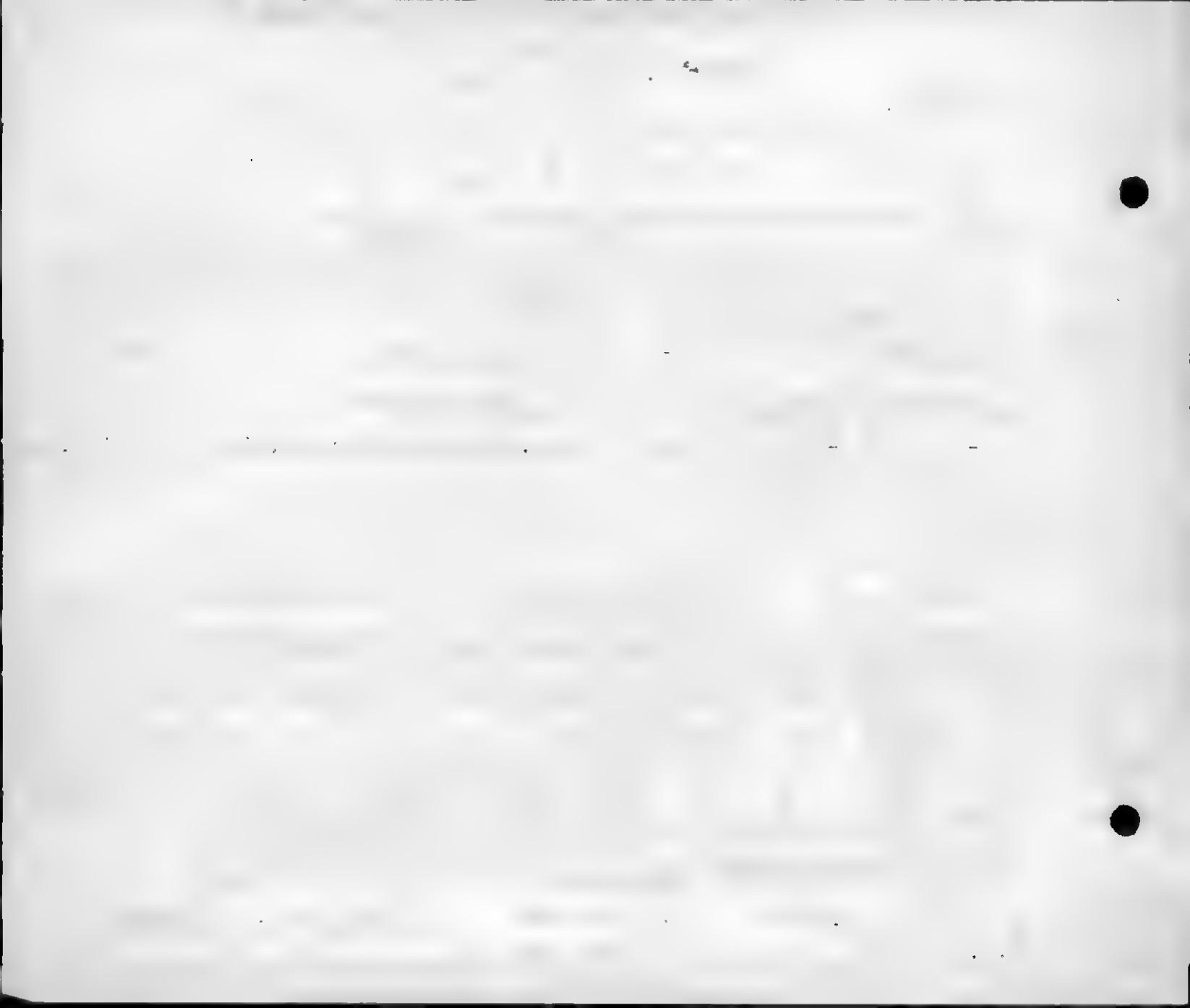
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Form 24 1-20-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No. 111325

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rosedale</b>		c. LENGTH OF STAY IN lb <b>15 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8118 Old Philadelphia Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>8118 Old Philadelphia Rd.</b>	
3. NAME OF DECEASED (Type or print) <b>MARY</b>		First <b>KRUL</b>	Middle <b>JANUARY</b>
4. DATE OF DEATH Month <b>11</b> Year <b>1960</b>		5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 1, 1885</b>	
9. AGE (In years lost birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>7</b> Days <b>14</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY - - -	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Martin Setera</b>		14. MOTHER'S MAIDEN NAME <b>Agnes Jonczak</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) - - -		16. SOCIAL SECURITY NO. 17. INFORMANT Address <b>Mrs. Teresa Kowalewski, 8118 Old Phila.Road</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b>		INTERVAL BETWEEN ONSET AND DEATH - - -	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>IMMEDIATE CAUSE (a)</b> <b>MYOCARDIAL INFARCTION</b>			
DUE TO - - - <b>HYPERTENSIVE CARDIOVASCULAR DISEASE</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>(State)</b>	
21. I certify that I attended the deceased from <b>August</b> , 19 <b>59</b> , to <b>JAN</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>JAN 11</b> , 19 <b>60</b> , and that death occurred at <b>9:30 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>8019 Philadelphia Rd.</b>	
ACTUAL SIGNATURE <b>John G. Orth, M.D.</b>		DATE SIGNED <b>1.11.60</b>	
PHYSICIAN'S NAME (Type) <b>John G. Orth</b>		8019 Philadelphia Road	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>St. Stanislaus</b>		22d. LOCATION (City, to <b>Baltimore</b> ) (State) <b>Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>M.F.SADOWSKI &amp; SONS, 1808 Eastern Ave</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 14 '60</b>	
ADDRESS <b>M.F.SADOWSKI &amp; SONS, 1808 Eastern Ave</b>		24b. REGISTRAR'S SIGNATURE <b>John S. Kraus</b>	



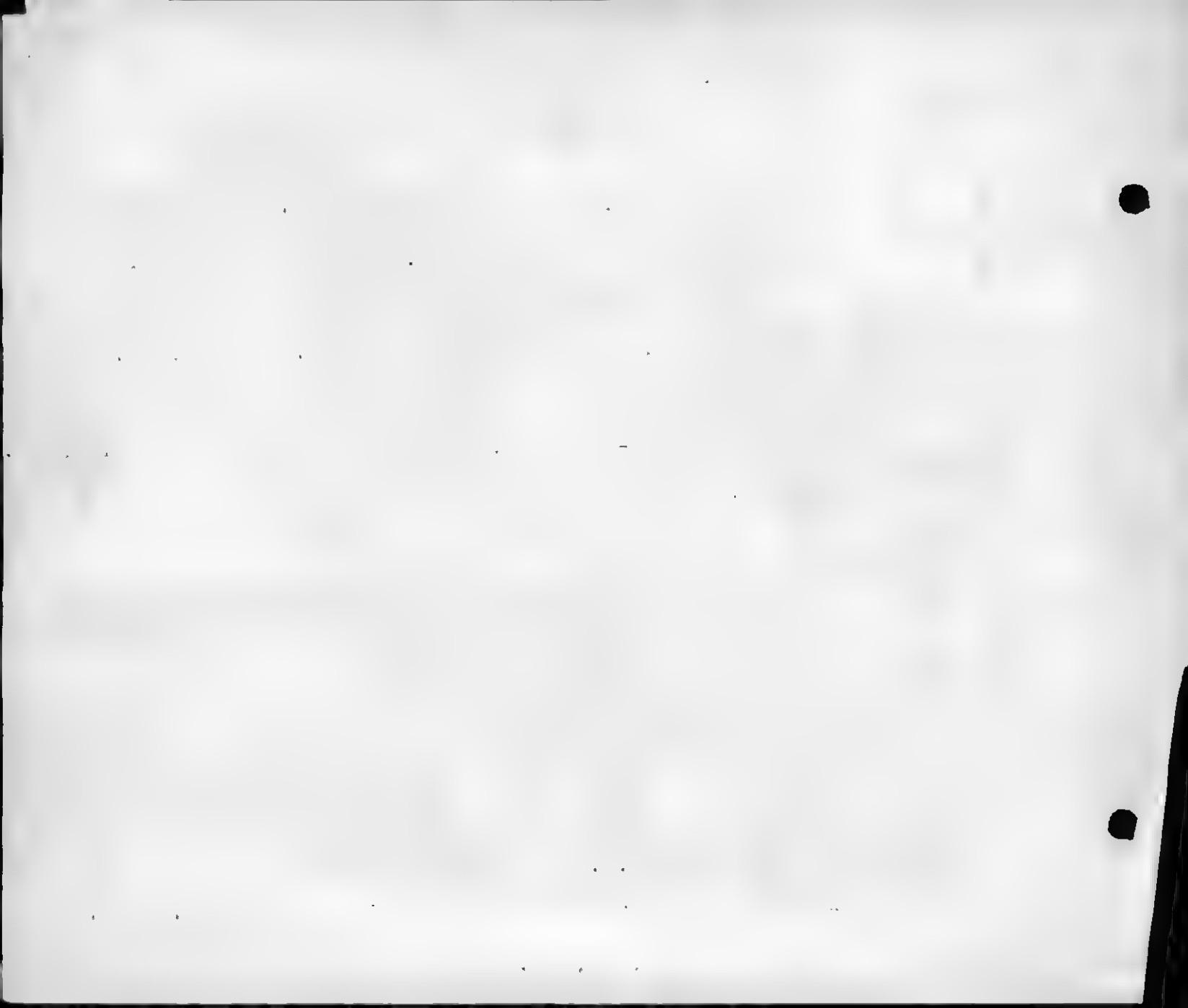
1 X  
FOR STATE  
HEALTH DEPT.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00326

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Baltimore		a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Dundalk		About 15 yr.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS	
Old North Point & Oakwood Roads		241 Ashwood Rd.	
e. IS RELATIONSHIP ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Albert Nelson			Lang Jr.
4. DATE OF DEATH		Month	Day
January 21, 1960			
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. AGE (In years at birthday)		9. IF UNDER 1 YEAR Months Days Hours Min	
47 48 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Foreman		Balto. County	Baltimore, Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Albert Lang		Gertrude Nelson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT
No None		218-05-9833	Mrs. Doris Lang 267 Colgate Ave. 22, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
1420.1		<i>Coronary Occlusion</i>	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)	
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Month, Day, Year 19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Melvin B. Davis, M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Melvin B. Davis, M.D.		DATE SIGNED <i>1/4 3/60</i>	
22a. BURIAL, CREMATION, REMOVAL (Select) Burial		22b. DATE THEREOF 1-25-1960	22c. NAME OF CEMETERY OR CREMATORIUM Sacred Heart of Jesus
22d. LOCATION (City, town, or county) German Hill Rd. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Duda 7922 Wise Ave. 22, Md.		24a. REC'D. BY REGISTRAR JAN 26 '60	24b. REGISTRAR'S SIGNATURE <i>John J. Duda</i>
ADDRESS		DATE	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

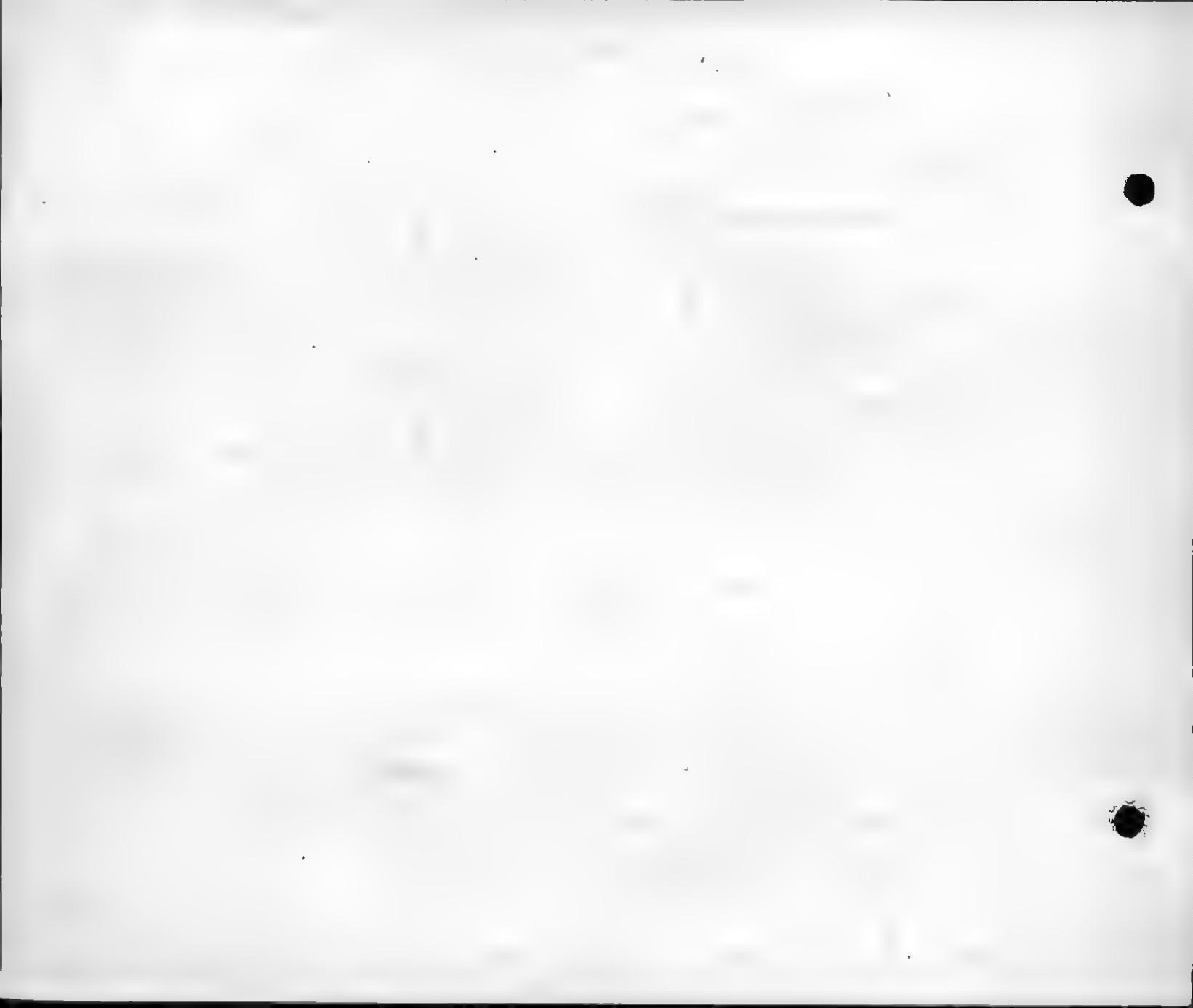
## CERTIFICATE OF DEATH

Reg. Dist. No.

111327

1. PLACE OF DEATH a. COUNTY		0345		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
<i>Baltimore</i>		MARYLAND		a. STATE <i>Md</i>	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
<i>Baltimore</i>				<i>Baltimore</i> 310-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<i>House in Pines</i>		<i>2708 Leestertown Rd</i>			
3. NAME OF DECEASED (Type or print)		First <i>Ida</i>	Middle <i>-</i>	Last <i>Lazerow</i>	4. DATE OF DEATH Month <i>1</i> Day <i>11</i> Year <i>1960</i>
5. SEX <i>Female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9. AGE (In years last birthday) <i>77</i> yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Russia</i>	
13. FATHER'S NAME <i>Slima</i>		14. MOTHER'S MAIDEN NAME <i>not known</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT <i>Julie Lazerow</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> INTERVAL BETWEEN ONSET AND DEATH <i>16</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Ch. Coronary Deterosis</i> 271 (c) <i>Ch. Hypertension Cardiac Vasculitis Disease</i> 1571					
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept. 10, 1958</i> to <i>January 11, 1960</i> , that I last saw the deceased alive on <i>January 9, 1960</i> , and that death occurred at <i>2 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>M.D. 6209 Frederick Ave.</i> DATE SIGNED <i>1/12/60</i>					
ACTUAL SIGNATURE <i>Wilmer K. Gollager</i>		PHYSICIAN'S NAME (Type) <i>Wilmer K. Gollager</i> Baltimore 28, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>1-12-60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>United Hebrew</i> 22d. LOCATION (City, town, or county) <i>Baltimore</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Jack Lewis Inc.</i>		ADDRESS <i>2100 Eutaw Place</i>		24a. REC'D BY REGISTRAR <i>JAN 12 '60</i>	24b. REGISTRAR'S SIGNATURE <i>C. S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



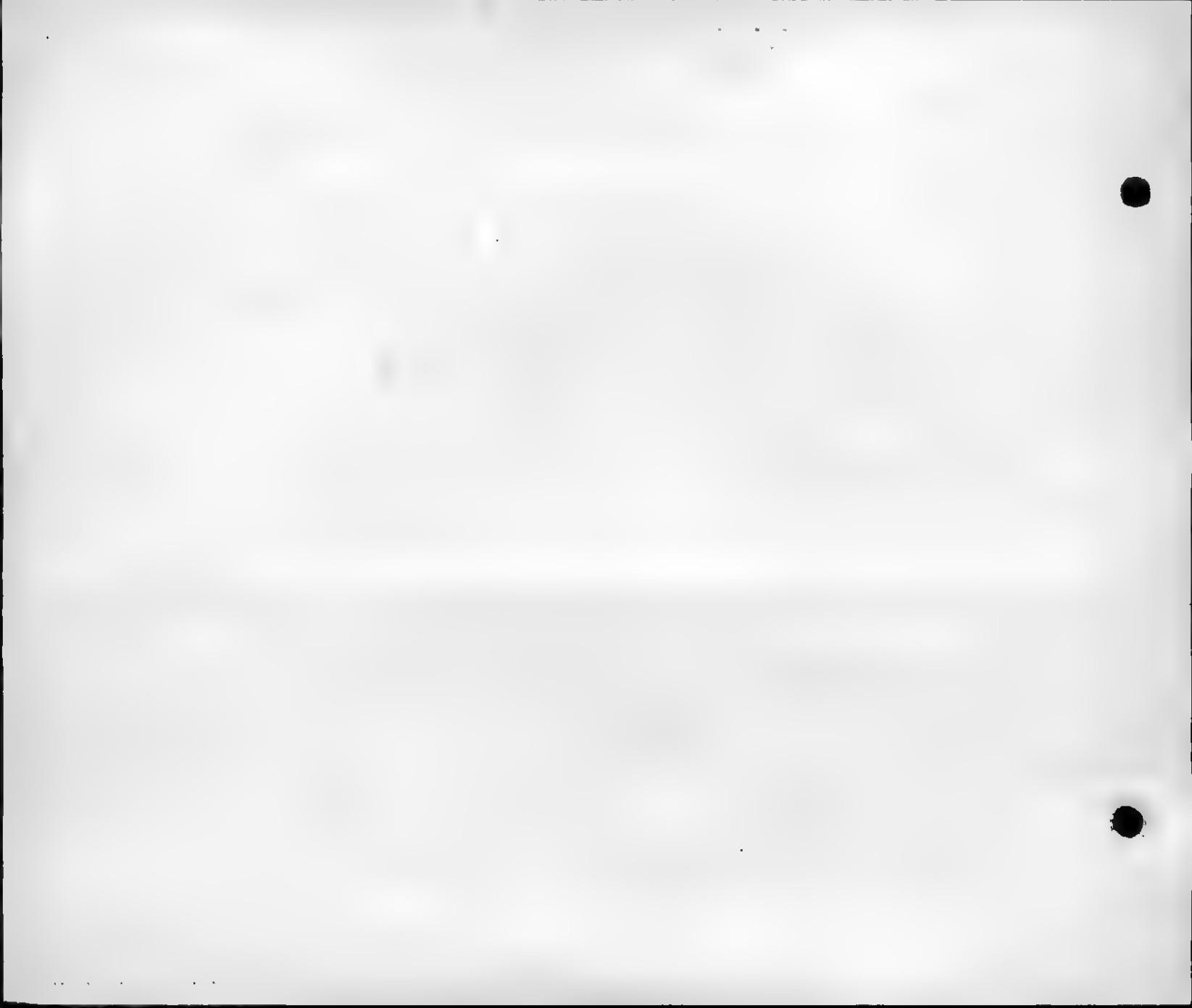
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death - Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
Item 1 Film 3-25 1/27/60 1wk  
**0348 CERTIFICATE OF DEATH**

Reg. Dist. No. 00328

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN lb <i>6.</i>	
d. NAME OF HOSPITAL (If in hospital, give address), OR INSTITUTION <i>Fairview Ave. Nursing Home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
3. NAME OF DECEASED (Type or print) <i>Wynona</i>		d. STREET ADDRESS <i>4022 Gold Spring</i>	
4. DATE OF DEATH <i>Jan 12 1960</i>		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F.</i>	6. COLOR OR RACE <i>W.</i>	7. MARRIED <input type="checkbox"/> NEVER-MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 28, 1886</i>
9. AGE (in years last birthday) <i>73 yr</i>		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
10c. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>John Strakler</i>		14. MOTHER'S MAIDEN NAME <i>Mary Nixon</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no or unknown) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Mrs Mary Ellendorf, Old County Ridge Rd</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> DUE TO <i>33IX</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Generalized arteriosclerosis</i> DUE TO (c)	
INTERVAL BETWEEN ONSET AND DEATH <i>2 da.</i>			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <i>Baltimore</i> (State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>0-11-1959</i> to <i>1-12-1960</i> , that I last saw the deceased alive on <i>1-22-1960</i> , and that death occurred at <i>10:45 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Wilmer K. Gallagher</i> ADDRESS (Street, city or town, state) <i>6209 Frederick Ave.</i> DATE SIGNED <i>1-12-60</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/15/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Baltimore Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers</i>		ADDRESS <i>8728 Liberty Rd.</i>	
		24a. REGD BY REGISTRAR <i>JAN 20 '60</i>	
		24b. REGISTRAR'S SIGNATURE <i>Wilmer K. Gallagher</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G255 1/27/60 iwk  
1034 CERTIFICATE OF DEATH

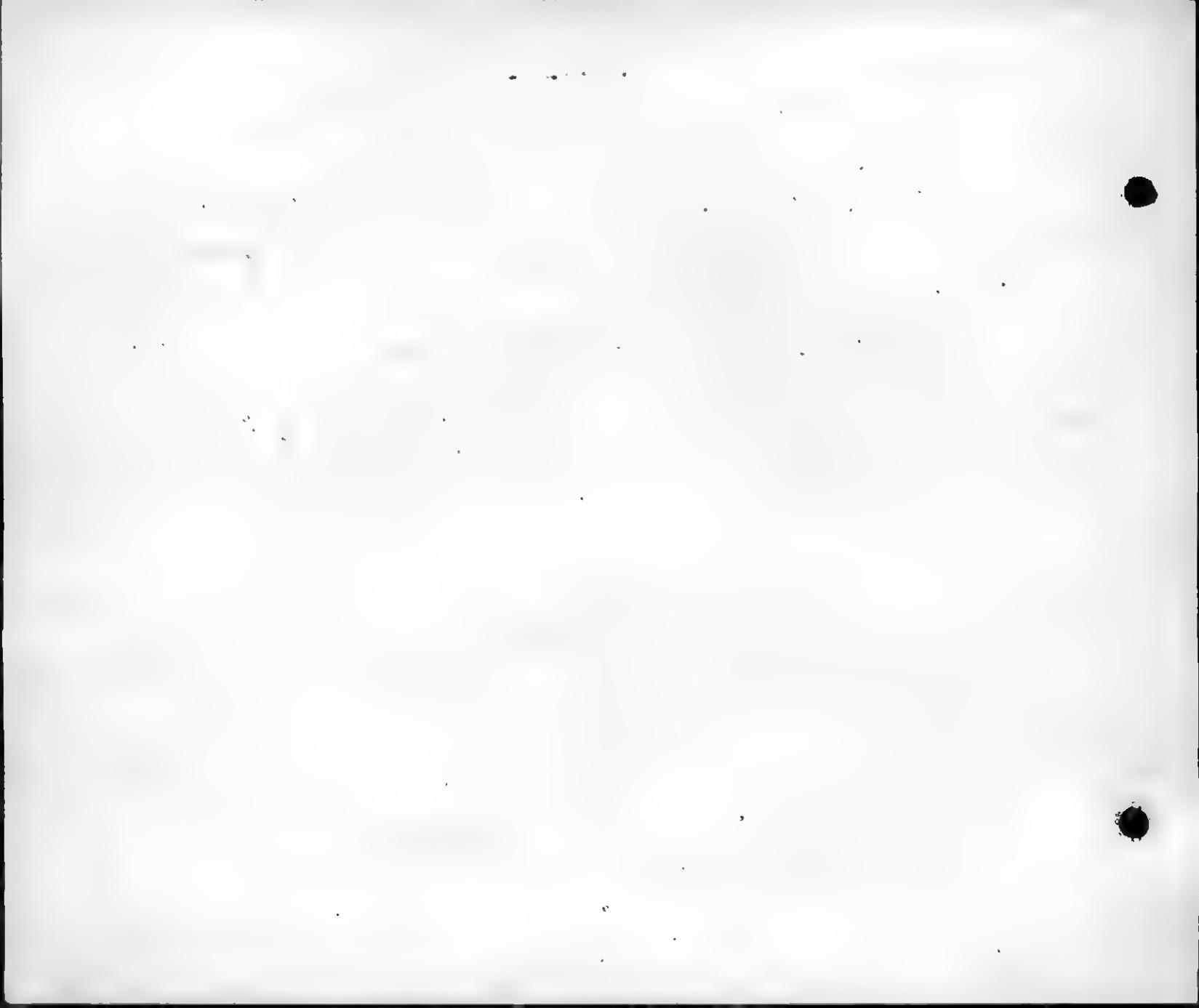
Reg. Dist. No

00329

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, interment, or removal, and in any event within 1/2 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Riversville	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Baltimore	3. V 21-4
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		527 Alter Avenue	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3802 Reisterstown Rd	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Female	White		Lentl	January	15	19	60
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min.	11. BIRTHPLACE (State or foreign country)	
			1890	69 yrs.		Russia	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		12 CITIZEN OF WHAT COUNTRY?		USA	
Housewife		At Home					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Bernard Aiken		Constance R?					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT		Address	
				Simon Lentl - 6106 First Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-vascular accident</u> INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>							
+ 22. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>ASCVD.</u>							
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
19							
21. I certify that I attended the deceased from <u>1/5</u> , 19 <u>60</u> , to <u>1/15</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1/15</u> , 19 <u>60</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8627 Liberty Rd</u> DATE SIGNED <u>1/16/60</u>							
ACTUAL SIGNATURE <u>M. J. Ellin</u>							
PHYSICIAN'S NAME (Type) <u>Morton J. Ellin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county) (State)	
Burial Jan 17/60				Pozvohlen Friendly		Baltimore, Md	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. FILED BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>Sol Lenson &amp; Bro - 6010 Reisterstown Rd</u>				DATE JAN 20 '60		<u>C. Wm. S. Knapp</u>	



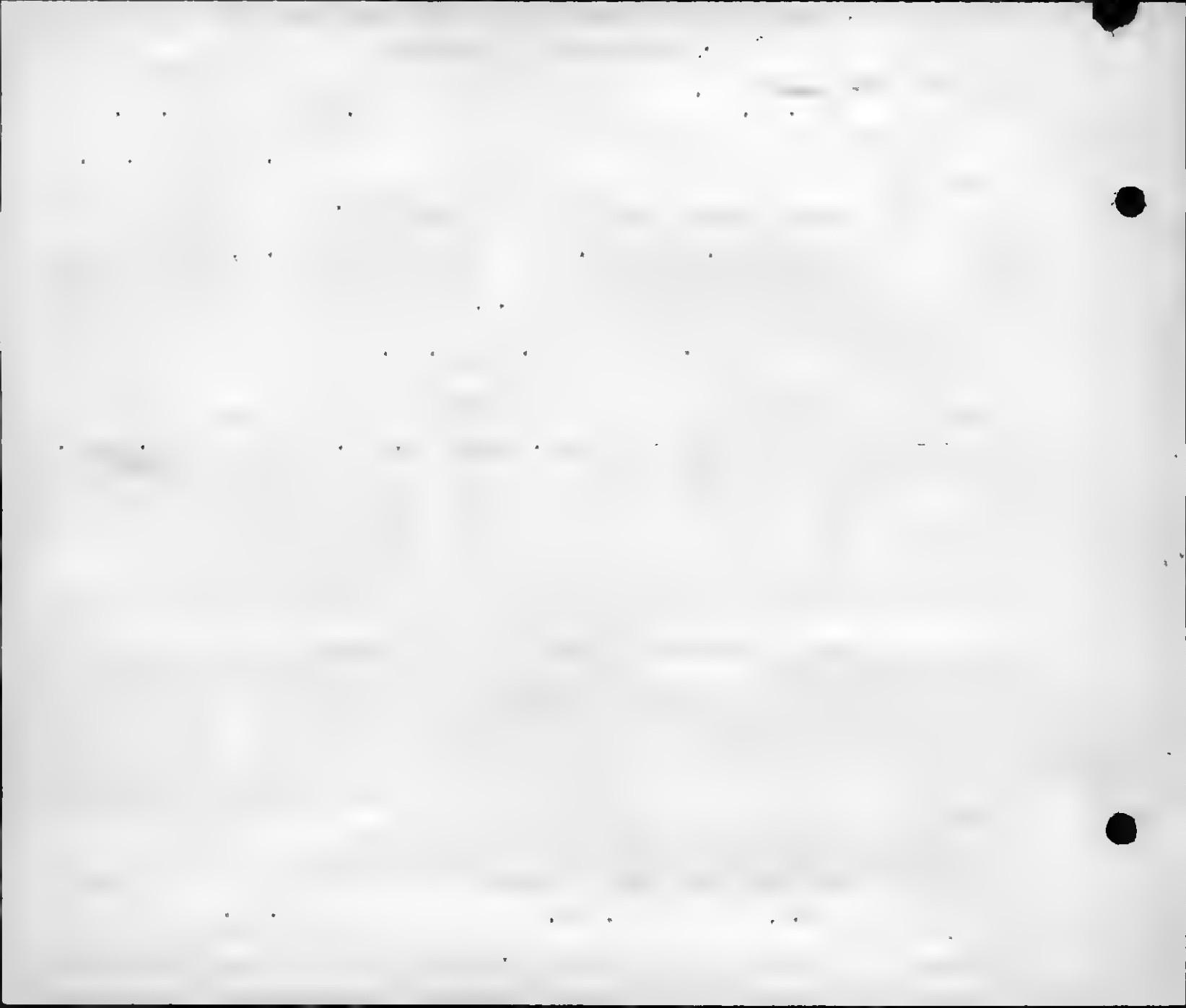
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 034 CERTIFICATE OF DEATH

Reg. Dist. No.

00330

1. PLACE OF DEATH a. COUNTY Balto. Co.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE 1800 Wilhelm Ave. 6 b. COUNTY Balto. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. LENGTH OF STAY IN 1b 5 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale Md. d. STREET ADDRESS 1800 Wilhelm Ave. 6	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First William	Middle S. Leyh Sr.
4. DATE OF DEATH Jan. 27, 1960		Last	Month Day Year 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 1, 1886
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Amer. Smelting Corp.	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ---Leyh		14. MOTHER'S MAIDEN NAME Lena Leohr	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----		16. SOCIAL SECURITY NO 212-10-1508	
17. INFORMANT Mrs. Margaret K. Leyh, 1800 Wilhelm Ave., Balto. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 44 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 yr. 2 days.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/21/59 to 1/27/60, that I last saw the deceased alive on 1/21/60, and that death occurred at 6:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE Dr. J. H. Klemm, M.D. 2529 Eastern Ave.		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 1, 1960	
22c. NAME OF CEMETERY OR CREMATORIAL Balto. Cem.		22d. LOCATION (City, town, or county) Balto. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Chryslering Son		24a. REC'D BY REGISTRAR ADDRESS 2024 Orleans St. 31	
		24b. REGISTRAR'S SIGNATURE FEB 1 '60	



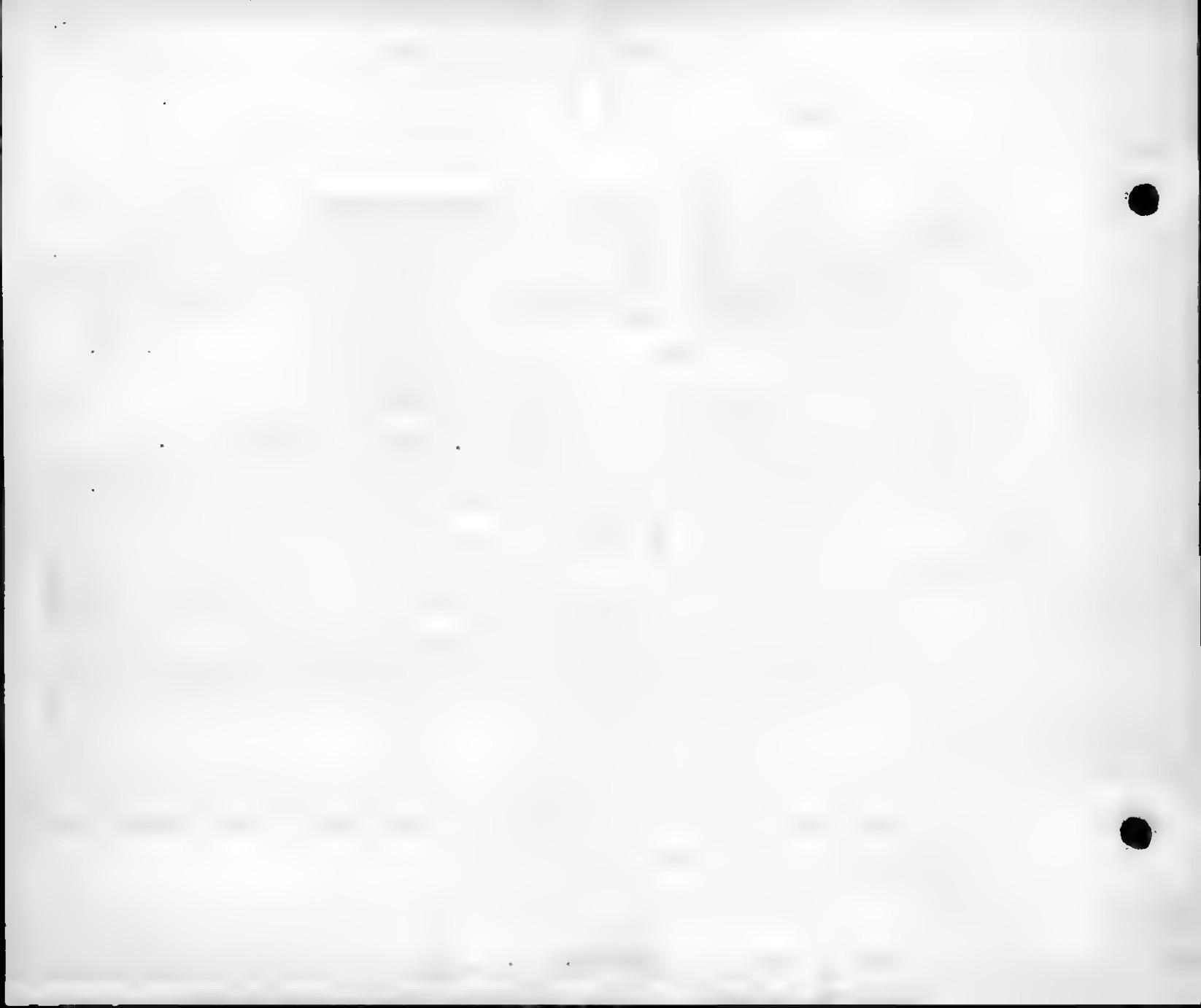
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0349 CERTIFICATE OF DEATH

Reg. Dist. No.

00331

1. PLACE OF DEATH o COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o STATE Maryland		b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 4		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Phoenix (Rural)				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Towson Convalescent Home				d. STREET ADDRESS XXXXXXXXXXXXXX		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mattie		First	Middle	Lost	4. DATE OF DEATH JANUARY 6 1960	Month	Day	Year
5. SEX F M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-3-1877	9. AGE (In years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months 4	IF UNDER 24 HRS Days 7	Hours 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HENRY Zinkhan		14. MOTHER'S MAIDEN NAME MARY SCH RIVER				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT George M. Lins, Phoenix, Md.		INTERVAL BETWEEN ONSET AND DEATH 7 days		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seas		DUE TO Cerebral hemorrhage				2 days.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		DUE TO Complication of pneumonia						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Diabetes Mellitus. And Seizing Anoxia						19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Jacksonville, Md.		(County) (State)
19								
21. I certify that I attended the deceased from December 9, 1960, to January 6, 1960, that I last saw the deceased alive on January 5, 1960, and that death occurred at 10:55 P.M. from the causes and on the date stated above.								
ACTUAL SITUATION Henry L. McCorkle				ADDRESS (Street, city or town, state) Jenettsville Rd., Phoenix, Md.		DATE SIGNED		
PHYSICIAN'S NAME (Type) Henry L. MC CORKLE MD								
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-11-60		22c. NAME OF CEMETERY OR CREMATORIAL United Church Christ		22d. LOCATION (City, town, or county) Jacksonville, Md.		(State)
23 FUNERAL DIRECTOR'S SIGNATURE Brooks Funeral Service, Towson 4, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 11 '60		24b. REGISTRAR'S SIGNATURE Orinus S. Thomas		

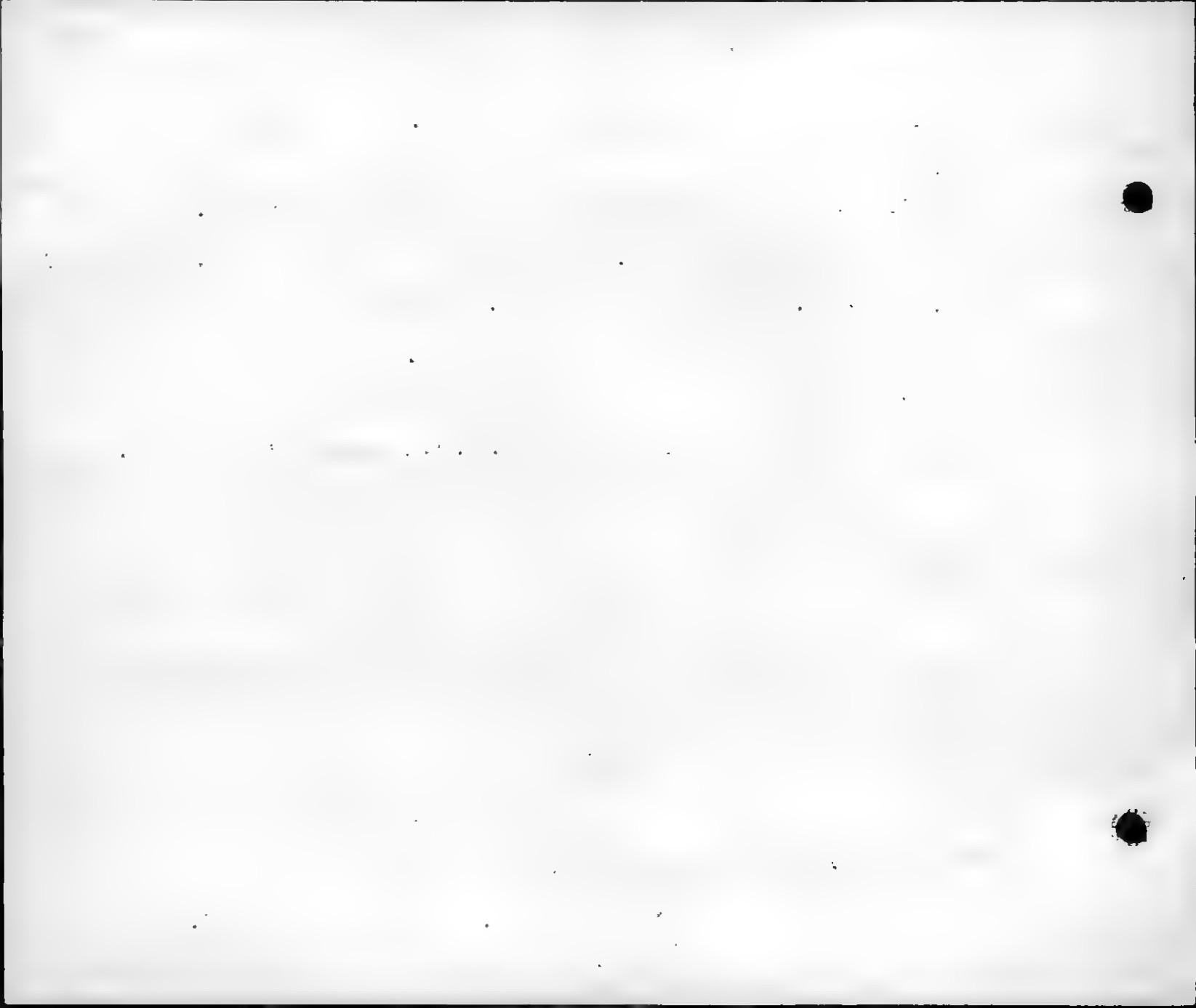


**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0350 CERTIFICATE OF DEATH**

Reg. Dist. No.

00332

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution Residence before admission) a. STATE <b>MD.</b>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>4906 Loch Raven Blvd.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>College Manor</b>										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ELZA</b>		First <b>W.</b>	Middle <b>LITTLE</b>	Last <b></b>	4. DATE OF DEATH <b>Jan. 10, 1960</b>	Month <b></b>	Day <b></b>	Year <b></b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 15, 1883</b>		9. AGE (In years last birthday) <b>76 yrs</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b>		IF UNDER 24 HRS Hours <b></b> Min <b></b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>Charles White</b>				14. MOTHER'S MAIDEN NAME <b>Sophia Bachler</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or date of service)		INFORMANT		Address <b>Mrs. J. C. Driscoll 417 Wingate Rd.</b>				
no		none								
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular penal disease</b>		DUE TO <b>44 dx</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b></b>		(b). DUE TO <b></b>								
(c). DUE TO <b></b>										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cirrhosis of liver</b>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b></b>	(State) <b></b>	
21. I certify that I attended the deceased from <b>June 28, 1957</b> , to <b>Jan 10, 1960</b> , that I last saw the deceased alive on <b>Jan 9, 1960</b> , and that death occurred at <b>12:15 P.M.</b> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>6100 York Rd., Belts-12nd st. Md.</b>		DATE SIGNED <b>1/10/60</b>		
ACTUAL SIGNATURE <b>Frederick J. Vollmer</b>		M.D.								
PHYSICIAN'S NAME (Type) <b>FREDERICK J. VOLLMER</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/12/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Druid Ridge Cem.</b>		22d. LOCATION (City, town, or county) <b>Pikesville, Md.</b>		(State) <b></b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.W. Sickner &amp; Sons - Batt 17</b>		ADDRESS <b></b>		24a. REC'D BY REGISTRAR <b>JAN 12 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kunes</b>				



## MARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE, 18

## 0351 CERTIFICATE OF DEATH

Reg. Dist. No. 00353

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

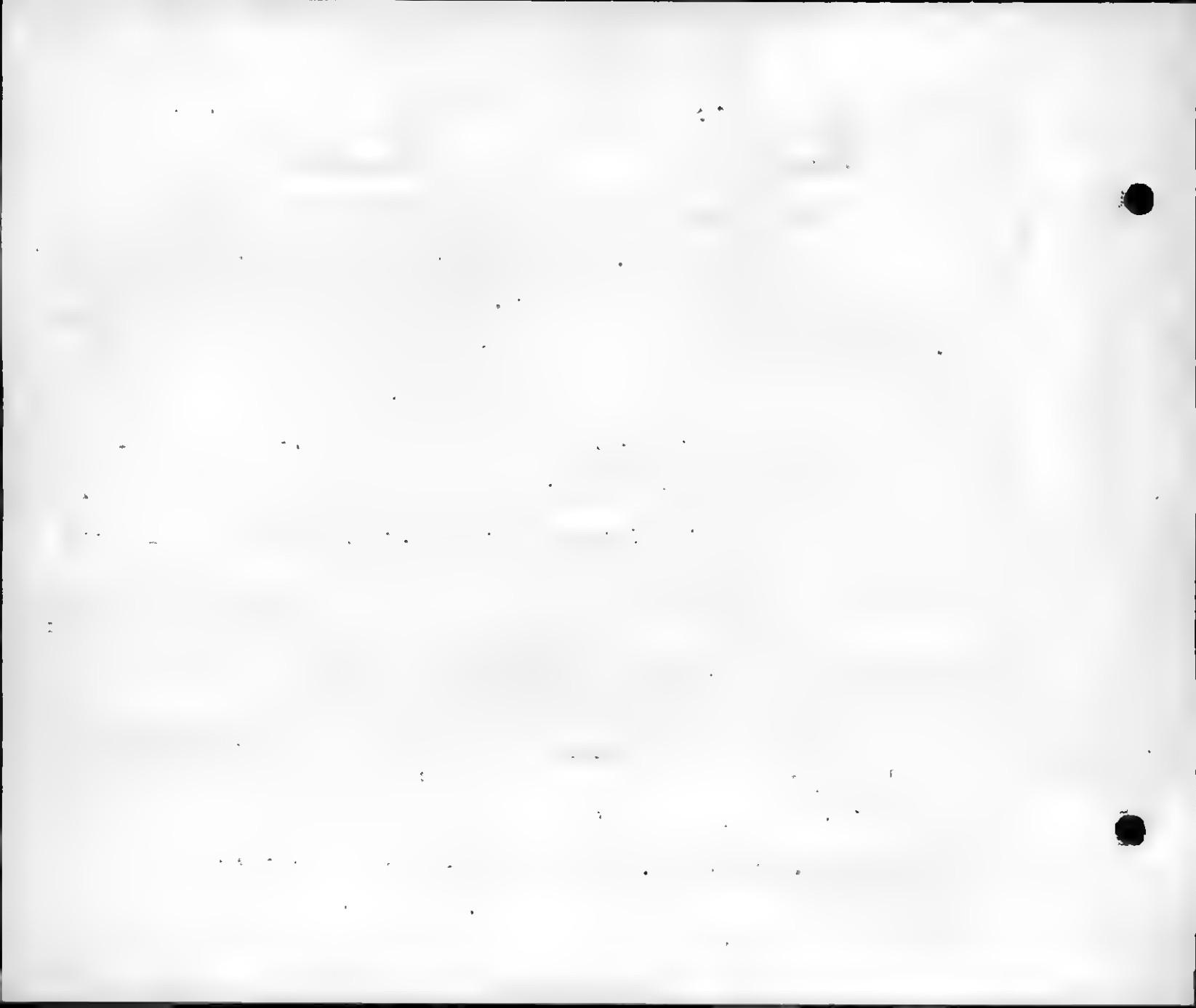
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, file in the funeral director. page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Balto.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Essex</i>		c. LENGTH OF STAY IN lb <i>30 yrs</i>	
d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN lb <i>4 Essex</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>213 EASTERN AVE</i>		d. STREET ADDRESS <i>213 Eastern Ave</i>	
3. NAME OF DECEASED (Type or print) <i>John Edwin Howe</i>		First <i>John</i>	Middle <i>Edwin</i>
Last <i>Howe</i>		Last <i>Jan</i>	Month <i>3</i>
4. DATE OF DEATH <i>Jan 3 1960</i>		Day <i>3</i>	Year <i>1960</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <i>April 26 1894</i>	
9. AGE (In years lost birthday) <i>65 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS Days <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Letter Carrier U.S. Gov.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Gov.</i>	
10c. BIRTHPLACE (State or foreign country) <i>Anh Arundel Md.</i>		12 CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i>John B. Howe</i>		14. MOTHER'S MAIDEN NAME <i>Carrie E. Boutin</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes one war</i>		16. SOCIAL SECURITY NO <i>Elie E. Wiesner 4304 Nicholas Ave</i>	
17. INFORMANT <i>None</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <i>Heart disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Disease</i> (b) DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH <i>10 yrs</i>	
19. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>No</i>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>None</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      Month Day Year p. m.      19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>		20f. (City or town) (County) (State) <i>Baltimore, Md. Baltimore, Md.</i>	
21. I certify that I attended the deceased from <i>June 1957</i> to <i>January 3 1960</i> that I last saw the deceased alive on <i>Jan 3 1960</i> , and that death occurred at <i>8:00 p.m.</i> from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <i>201 E 15th Avenue</i>	
ACTUAL SIGNATURE <i>John E. Gessner</i>		DATE SIGNED <i>John E. Gessner</i>	
PHYSICIAN'S NAME (Type) <i>JOHN E. GESSNER</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>	
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22c. DATE THEREOF <i>1-6-60</i>	
22d. NAME OF CEMETERY OR CREMATORIUM <i>Druide Ridge Cem.</i>		22e. LOCATION (City, town, or county) (State) <i>Baltimore Co. Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Huppel Bros 7110 Belair Rd.</i>		24a. ADDRESS <i>Arthur S. Kraus</i>	
		24b. REC'D. BY REGISTRAR DATE <i>JAN 6 '60</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>												00334			
<b>0352 CERTIFICATE OF DEATH</b>												Reg. Dist. No.			
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)									
a. COUNTY		Baltimore		MARYLAND		a. STATE		Maryland		b. COUNTY		Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM?			
<i>Marlboro</i>						<i>Marlboro</i>				13600 Kelox Road #7		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		3600 Kelox Road													
3. NAME OF DECEASED (Type or print)		First ALBERT		Middle F.		4. DATE OF DEATH		Month Jan.		Day 18		Year 19 60			
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS			
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Jan. 31, 1883		76 yrs.		Months		Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12 CITIZEN OF WHAT COUNTRY?			
Retired Auto Salesman								Baltimore, Maryland							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME											
Rheinhold Maldeis				Amalie Melcher											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address									
No		213-01-4009		Mr. Albert Maldeis, Jr.-749 Charing Cross Road											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												1 hour			
420.1 Coronary Occlusion															
DUE TO															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerotic cardiovascular disease												10 years			
DUE TO (c)															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF YES, SEE MARYLAND MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) *****											
20c. TIME OF INJURY Month October Year 1958 Hour a m 12 p m 19				20d. INJURY OCCURRED While Not white at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****				20f. (City or town) *****		(County) ***** (State) *****	
21. I certify that I attended the deceased from October 19, 1958, to Jan 19, 1960, that I last saw the deceased alive on 15 January, 1960, and that death occurred at 4:00 AM from the causes and on the date stated above.												ADDRESS (Street, city or town, state) M.D. 5101 Gwynn Oak Avenue, Baltimore, 7, Maryland			
ACTUAL SIGNATURE <i>Millard T. Traband</i>												DATE SIGNED			
PHYSICIAN'S NAME (Type) Millard T. Traband, Jr.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/20/60		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge Cemetery		22d. LOCATION (City, town, or county) Pikesville, Maryland		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. J. Leckner</i>		ADDRESS <i>Balto - 17 Mid.</i>		24a. REC'D BY REGISTRAR DATE JAN 20 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>									



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 155 10W

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

011305

## CERTIFICATE OF DEATH

0353

Reg. Dist. No. 32

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR end give nearest town)	MARYLAND LENGTH OF STAY (in this place) <i>19 days</i>	STATE CITY (If outside corporate limits, write RURAL and give nearest town)	COUNTY STREET ADDRESS (If rural give location)
TOWN Mt. Wilson		TOWN Mt. Wilson	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mt. Wilson State Hospital</i>			
<b>3. NAME OF DECEASED</b> (First) <i>JOSEPH PATRICK McNAMARA</i> (Middle) (Last)		<b>4. DATE (Month) OF DEATH</b> <i>January 26, 1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>April 5, 1896</i>
9. AGE last birthday <i>59 yrs.</i>	10. KIND OF BUSINESS OR INDUSTRY <i>Food Distributor</i>	11. BIRTHPLACE (State or foreign country) <i>Philadelphia, Pennsylvania</i>	12. CITIZEN OF WHAT COUNTRY? <i>America</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11a. INFORMANT & ADDRESS Hospital Records Mt. Wilson State Hospital	
13. FATHER'S NAME <i>John Joseph McNamara</i>		14. MOTHER'S MAIDEN NAME <i>BRIDGET H. McNAMARA</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-36-8174</i>	
<b>17. MEDICAL CERTIFICATION</b>			
I. IMMEDIATE CAUSE (A) <i>Pneumonia</i> DUE TO ANTECEDENT CAUSE(S) (B) _____ DISEASES OR CONDITIONS, IF ANY, (C) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>New Cathedral Cemetery</i>	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1/1/66</i> to <i>1/26, 1966</i> , that I last saw the deceased alive on <i>1/1/66</i> , and that death occurred at <i>11:30 A.M.</i> from the causes and on the date stated above. SIGNATURE _____ ADDRESS (Street, city, town, state) _____ DATE SIGNED _____			
Wm. Newcomer, M.D. Superintendent, Mt. Wilson, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>1/29/66</i>	NAME OF CEMETERY OR CREMATORIAL <i>New Cathedral Cemetery</i>	LOCATION (City, town, or county) (State)
24. REC'D BY REGISTRAR <i>John S. Kress</i>	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE <i>Charles L. Stevens Funeral Home Inc.</i>	
DATE 2/9/66		ADDRESS <i>1601 E. Fort Ave.</i>	



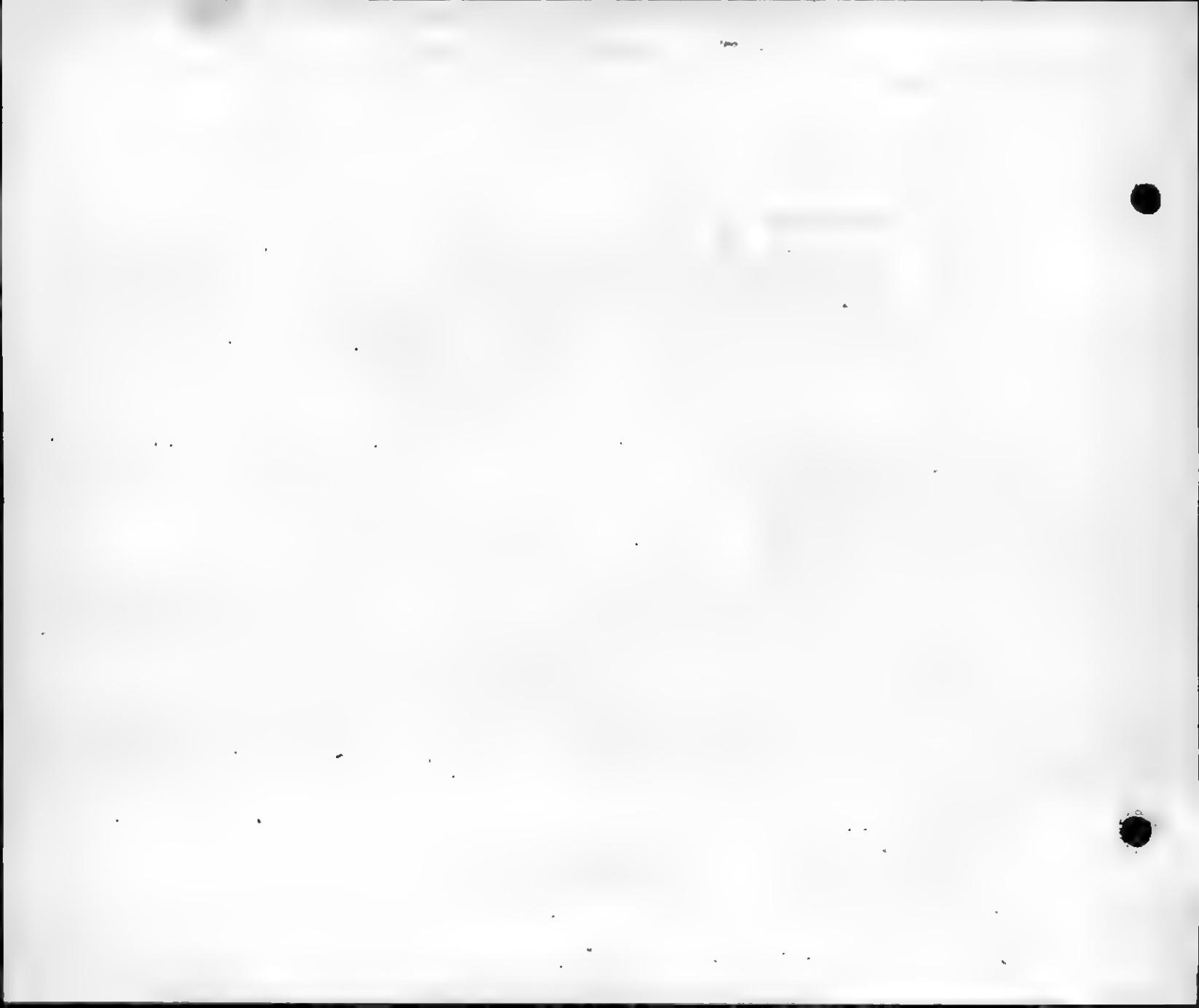
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00336

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Woodlawn	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1612 Ingleside Avenue	d. STREET ADDRESS 1612 Ingleside Avenue #7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) ADELE	First LUCKETT	Middle MANTLER	4. DATE OF DEATH January 25
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1900
9. AGE (In years last birthday) 59 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Punch Press Operator	11. KIND OF BUSINESS OR INDUSTRY Western Electric Co.	12. BIRTHPLACE (State or foreign country) Baltimore, Maryland
13. CITIZEN OF WHAT COUNTRY?	14. MOTHER'S MAIDEN NAME Mary Luckett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 214-20-5816	INFORMANT Miss Helen A. Mantler-1612 Ingleside Avenue	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO C. v.a. Rt Sider 3 days		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>58</u> to <u>1/25</u> , 19 <u>60</u> that I last saw the deceased alive on <u>1/25</u> , 19 <u>60</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE CLIFF RATLIFF, S. M.D.	4605 EDMONDSON AVE BALTIMORE MD		
PHYSICIAN'S NAME (Type) CLIFF RATLIFF, S. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/28/60	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery	22d. LOCATION (City, town, or county) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Pickner & Son	ADDRESS Baltimore - 17 Md.	24a. REC'D BY REGISTRAR JAN 27 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thane



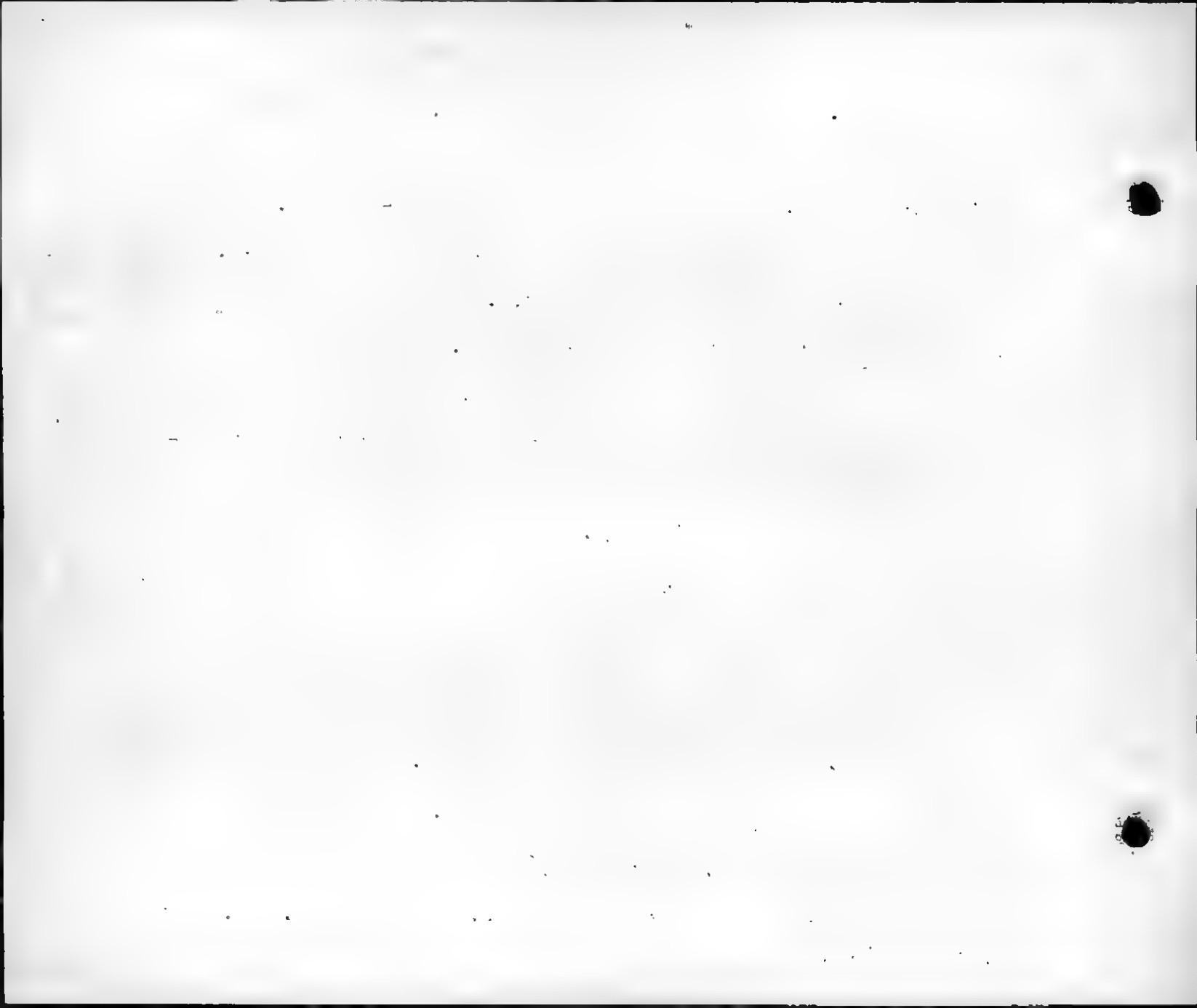
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0355 CERTIFICATE OF DEATH

Reg. Dist. No.

00357

1. PLACE OF DEATH a. COUNTY <b>Balto.</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Caton Ridge Nursing Home</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home</b>		e. STREET ADDRESS <b>5701 - 1st Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>LEWIS</b>	Middle <b>EDWARD</b>	Last <b>MARKS</b>
4. DATE OF DEATH	Month <b>Jan.</b>	Day <b>15,</b>	Year <b>1960</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 19, 1870</b>
9. AGE (In years last birthday) <b>89 yrs</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired (Signal Maintenance)</b>	11. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	12. BIRTHPLACE (State or foreign country) <b>Md.</b>
13. FATHER'S NAME <b>?</b>	14. MOTHER'S MAIDEN NAME <b>?</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO <b>none</b>	INFORMANT <b>Mrs. Ruth Leatherwood</b>	Address <b>Hanover, Md. Box 232-Forest Rd.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			
<b>450.0</b>			
DUE TO			
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO			
(c)			
<b>Pulmonary edema</b>			
<b>Cardiac failure</b>			
<b>Arterio sclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
AGE			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
<b>19</b>			
21. I certify that I attended the deceased from <b>July 1, 1960</b> to <b>Dec 12, 1960</b> , that I last saw the deceased alive on <b>Dec 15, 1960</b> , and that death occurred at <b>149 M.</b> from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>1405 Edmondson Ave.</b>			
DATE SIGNED <b>1/16/60</b>			
ACTUAL SIGNATURE <b>Cecil Ratliff Jr.</b>			
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF JR.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/18/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cem.</b>
22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Sicker &amp; Sons - Balt. 17</b>			
ADDRESS <b>1100 N. Charles St.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0350 CERTIFICATE OF DEATH

Reg. Dist. No.

00358

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 13 Kingsley Road		d. STREET ADDRESS 13 Kingsley	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

3. NAME OF DECEASED (Type or print)	First Allen	Middle Mason	Last Marquess	4. DATE OF DEATH Jan. 15, 1960	Month Jan.	Day 15	Year 1960
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5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1926	9. AGE (In years lost birthday) 33 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.
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13. FATHER'S NAME Mason E. Marquess	14. MOTHER'S MAIDEN NAME Ida May Allen
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO None	17. INFORMANT Mason E. Marquess, Owings Mills, Md.	Address
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18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X Lobar Pneumonia	INTERVAL BETWEEN ONSET AND DEATH 5 days
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) _____ DUE TO _____ (c) _____ DUE TO _____	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Multiple birth defects especially, malformation of chest		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		
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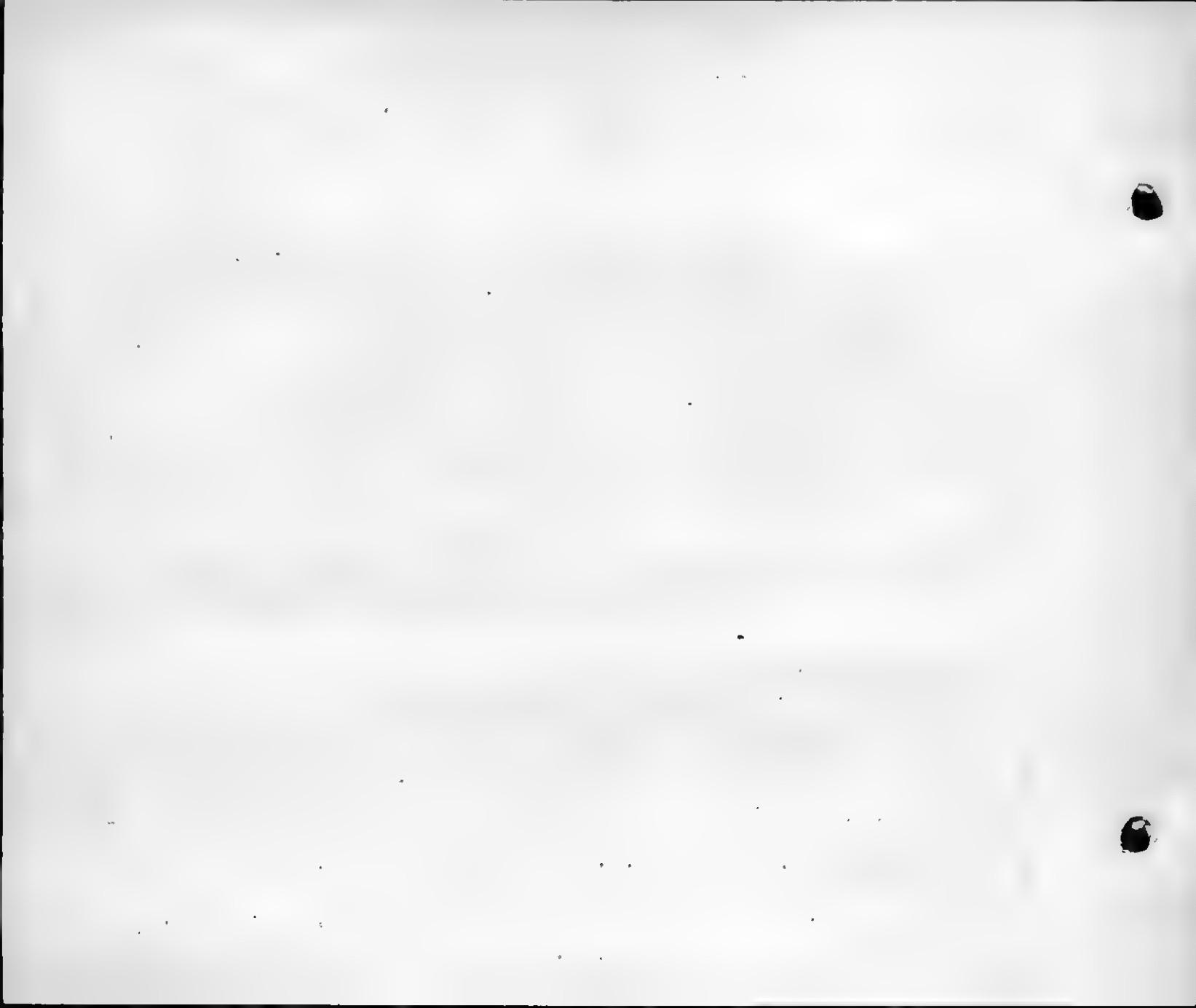
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Reisterstown	(County)	(State)
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21. I certify that I attended the deceased from January 1, 1955, to January 1, 1960, that I last saw the deceased alive on January 15, 1960, and that death occurred at 12 P.M. from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Martin E. Strobel</i>	ADDRESS (Street, city or town, state) 18 Main Street							DATE SIGNED 1-1-60

POLICE PHYSICIAN'S NAME (Type) Martin F. Strobel M.D.	Reisterstown, Maryland	
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22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 18/60	22c. NAME OF CEMETERY OR CREMATORIUM All Saints	22d. LOCATION (City, town, or county) Reisterstown, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons, Reisterstown, Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 21 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
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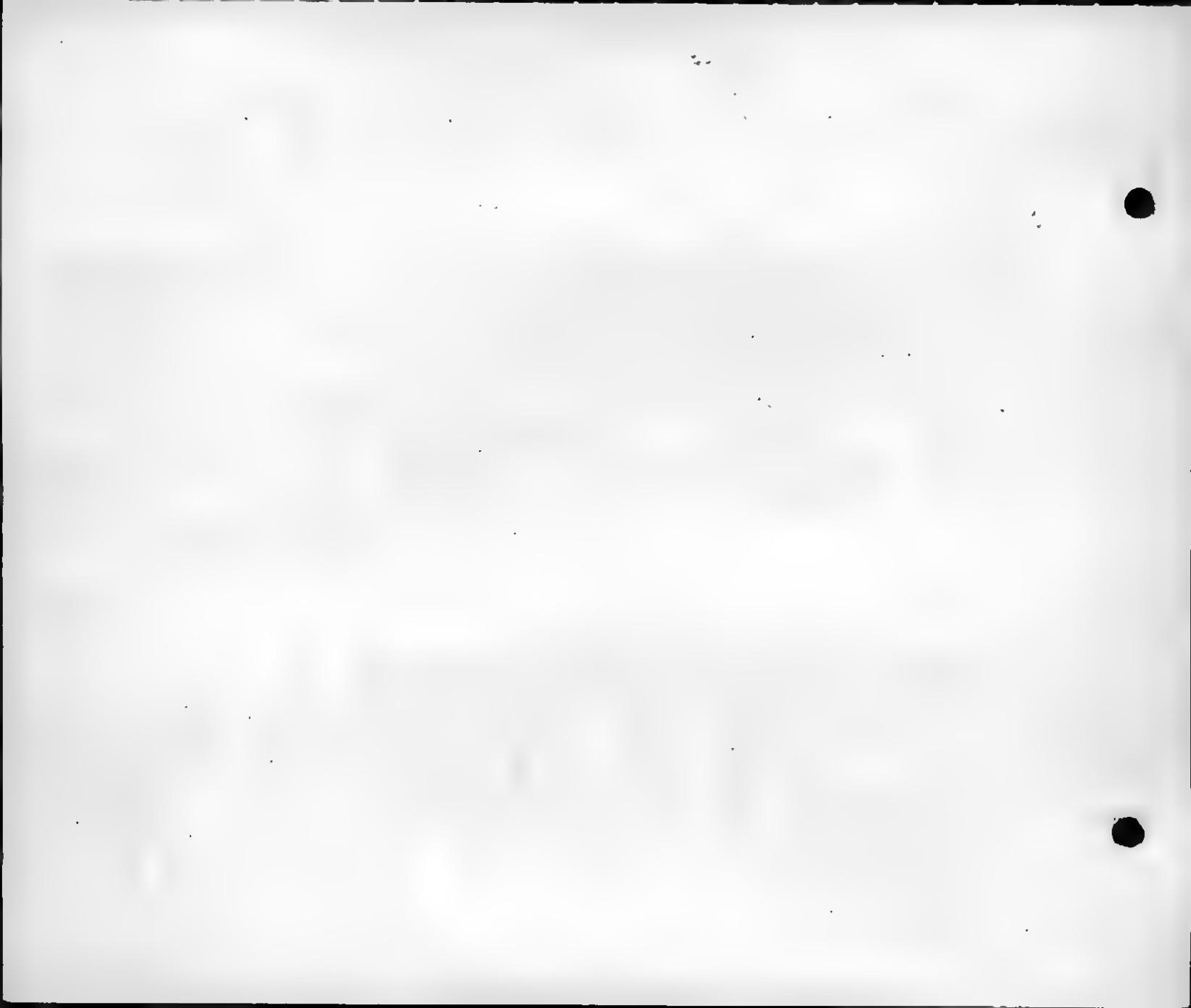
**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the State Board of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

00359

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <i>Balto. Co.</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN lb <i>203 N. Rolling Rd</i>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <i>Ind.</i>		b. COUNTY <i>Balto.</i>	
						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>203 N. Rolling Rd</i>		d. STREET ADDRESS <i>203 N. Rolling Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <i>Thomas E. Massey</i>		First	Middle	Last	4. DATE OF DEATH <i>Jan. 28</i>	Month	Day	Year	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>12/15/79</i>	AGE (In years last birthday) <i>80 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>	IF UNDER 24 HRS Hours <i>0</i>	IF UNDER 24 HRS Days <i>0</i>	
10a. JSLAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) <i>retired B.T.O. P.R. R.</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Joseph Massey</i>		14. MOTHER'S MAIDEN NAME <i>Jones</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>123-45-6789</i>		17. INFORMANT <i>Thomas E. Massey</i>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b)</i>		Coronary Thrombosis.		INTERVAL BETWEEN ONSET AND DEATH			
DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(c)</i>				Generalized Arteriosclerosis Extensive.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>April 1959</i>		20f. (City or town) <i>1/28/60</i>		(County) <i>Howard Co.</i>	(State) <i>Ind.</i>
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, ta _____, that (I) (we) last saw the deceased alive on _____, and that death occurred on _____ from the causes and on the date stated above.									
22a. SIGNATURE <i>W.E. McGrath</i>		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>1/29/60</i>		
22c. PHYSICIAN'S NAME (Type) <i>W.E. McGrath</i>		22d. ADDRESS <i>1303 Frederick Rd. Catonsville 28 md.</i>							
23a. BUR. A., CREMAT. ON, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2/1/60</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. View</i>		23d. LOCATION (City, town, or county) <i>Howard Co. Ind.</i>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John Daff &amp; Son</i>		ADDRESS <i>28</i>		25a. REC'D. BY REGISTRAR DATE <i>FEB 1 '60</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>			



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0358

**CERTIFICATE OF DEATH**

00340

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>5yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		d. STREET ADDRESS <b>1923 Old Frederick Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1923 Old Frederick Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>David H. Matthews</b>		First <b>David</b>	Middle <b>H. Matthews</b>	Last <b></b>	4. DATE OF DEATH <b>Jan. 23</b>	Month <b>Jan.</b>	Day <b>23</b>	Year <b>1960</b>	
S SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1893</b>	9. AGE (In years last birthday) <b>66 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a JSJAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tank Tester</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Boiler Ind.</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S.</b>			
13. FATHER'S NAME <b>Joseph Matthews</b>				14. MOTHER'S MAIDEN NAME <b>Etta Drener</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17 INFORMANT <b>Mrs. Anna M. Matthews</b>		Address <b>Same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>PNEUMONIA, BILATERAL</b> 490 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO (d) DUE TO (e) DUE TO (f) DUE TO (g) DUE TO (h) DUE TO (i) DUE TO (j) DUE TO (k) DUE TO (l) DUE TO (m) DUE TO (n) DUE TO (o) DUE TO (p) DUE TO (q) DUE TO (r) DUE TO (s) DUE TO (t) DUE TO (u) DUE TO (v) DUE TO (w) DUE TO (x) DUE TO (y) DUE TO (z)									
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore Co.</b>	(State) <b>Md.</b>
21 I certify that (I) (this hospital) attended the deceased from <b>July 1953</b> to <b>JAT. 1/23 1960</b> , that (I) (we) lost saw the deceased alive on <b>1/23 1960</b> , and that death occurred at <b>12 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Herbert W. Lapp</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22b. DATE <b>Jan 25, 1960</b>					
22c. PHYSICIAN'S NAME (Type) <b>Herbert W. Lapp M. D.</b>		22d. ADDRESS <b>4804 Frederick Rd. Balt. 29, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/27/60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn Cemetery</b>		23d. LOCATION (City, town, or county) <b>Woodlawn Balt. Co., Md.</b>			(State) <b>Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>George Horne</b>		ADDRESS <b>4001 Ritchie Hwy.</b>		25a. REC'D BY REGISTRAR <b>JAN 29 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			



**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**0221 CERTIFICATE OF DEATH**

00341

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b <b>RURAL Dundalk</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1932 Cedar Lane</b>		d. STREET ADDRESS <b>1932 Cedar Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF <b>FRANK</b> (Type or print)	First <b>X.</b>	Middle <b>MAURER</b>	4. DATE OF DEATH <b>January 6, 1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 4, 1890</b>
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) <b>69 yrs.</b>	
10a. LSELIAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Penna</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Christian Maurer</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Pfeifer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Helen T. Maurer 6 Playfield</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
<i>Coronary occlusion</i>			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <i>Pulmonary Emphysema</i>			
DUE TO			
(c) <i>Duodenal ulcer</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/24</b> , 19 <b>55</b> , to <b>1/6</b> , 19 <b>60</b> , that (II) (we) last saw the deceased alive on <b>1/6</b> , 19 <b>60</b> , and that death occurred at <b>3 PM</b> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Eugene F. Nevy</i>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>Eugene F. Nevy</i>		22d. ADDRESS <b>7001 Morningside Road Baltimore Md.</b>	
23a. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/9/60</b>	
23c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart</b>		23d. LOCATION (City, town, or county) (State) <b>Dundalk, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ullrich Funeral Home Dundalk, Md.</b>		ADDRESS	
		25a. REC'D BY REGISTRAR DATE <b>JAN 12 '60</b>	
		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0359 CERTIFICATE OF DEATH

Reg. Dist. No.

06342

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>1 yr.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		d. STREET ADDRESS <u>808 Southridge Rd</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Southridge Rd</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Edward</u>		First	Middle	Last	4. DATE OF DEATH <u>MARZEO</u>	Month	Day	Year
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1890</u>	9. AGE (In years lost birthday) <u>69 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BAKING</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>YAZZEO</u>		INFORMANT <u>MARIE MARZEO</u>		Address <u>808 Southridge Rd</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>350X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Hemorrhaged Anterior</u> (c) <u>Paroxysms of pain</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>9-19-1919</u> , to <u>1-7-60</u> , that I last saw the deceased alive on <u>1-1-60</u> , 19_____, and that death occurred at <u>7 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>4615 Shandon Dr</u>						
ACTUAL SIGNATURE <u>HARRY S. GIMBEL</u>		DATE SIGNED <u>1-6-60</u>						
PHYSICIAN'S NAME (Type) <u>HARRY S. GIMBEL</u>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-8-60</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>LONDON PARK</u>		22d. LOCATION (City, town, or county) <u>BALTIMORE MD</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO L. SCHWAB FUNERAL HOME</u>		ADDRESS <u>Francis St Miller 2101 Frederick Ave.</u>		24a. REC'D BY REGISTRAR <u>JAN 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		



THIS IS A PERMANENT RECORD.  
ITEM OF INFORMATION SHOULD BE CAREFULLY AND NEATLY SUPPLIED.  
SE WRITE THE CAUSES OF DEATH CLEARLY AND NEATLY.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

**CERTIFICATE OF DEATH**

078343

1. NAME OF DECEASED  
(Type or Print)

Mary Rose McCarthy

DATE OF DEATH  
January 26, 1960

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

Baltimore County  
(If not in hospital or institution, give street  
address or location)

Armacost Nursing Home

4. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)

A. STATE

Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

(If outside city limits, write RURAL and give township)

D. STREET ADDRESS

3803 Elerslie Ave.

(If rural, give location)

5. SEX

6. COLOR OR RACE

Female

white

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

single

10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even  
if retired)

housekeeper

10B. KIND OF BUSINESS OR INDUSTRY

Church Rectory

B. DATE OF BIRTH

August 11, 1887 72

9. AGE (In years  
last birthday)

If Under 1 Year  
Months Days Hours Min.

13. FATHER'S NAME

Dennis McCarthy

14. MOTHER'S MAIDEN NAME

Ann Sweeney

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

none

16. SOCIAL  
SECURITY NO.

215-05-9112

17. INFORMANT

Michael J. McCarthy 3803 Elerslie Ave.

ADDRESS

18. 154X I

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

CAUSE OF DEATH

(A) Carcinoma of colon  
DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

15 mos.

(B) Carcinoma of rectum  
DUE TO

?

(C) \_\_\_\_\_

(Arteriosclerotic cardiovascular disease)

?

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

Oct 1958

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Car. of rectum

20. AUTOPSY?

YES

NO

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING   
OR CONTRIBUTING  CAUSE OF

21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)

21C. WHERE DID  
INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from

Jan 26, 1960 that (I) (we) last saw the deceased alive on  
and that in (my) (our) opinion death occurred at 11:15 A.M. from the causes and on the date stated above.

Sept 24 1958  
Jan 26, 1960

23A. SIGNATURE

ATTENDING PHYS.

MED DIRECTOR

STAFF PHYS.

23B. ADDRESS

6100 York Rd - 12

23C. DATE SIGNED

Jan 27, 1960

REMOVAL  
(Specify)

Burial

24B. DATE

Jan 29, 1960

24C. NAME OF CEMETERY OR CREMATORIUM

New Cathedral Cemetery

24D. LOCATION

(City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 29 '60

25B. NAME OF REGISTRAR

Arthur S. Mann

25C. FUNERAL DIRECTOR

John A. Moran 3000 E. Baltimore St.

ADDRESS



1  
FOR STATE  
HEALTH DEPT.



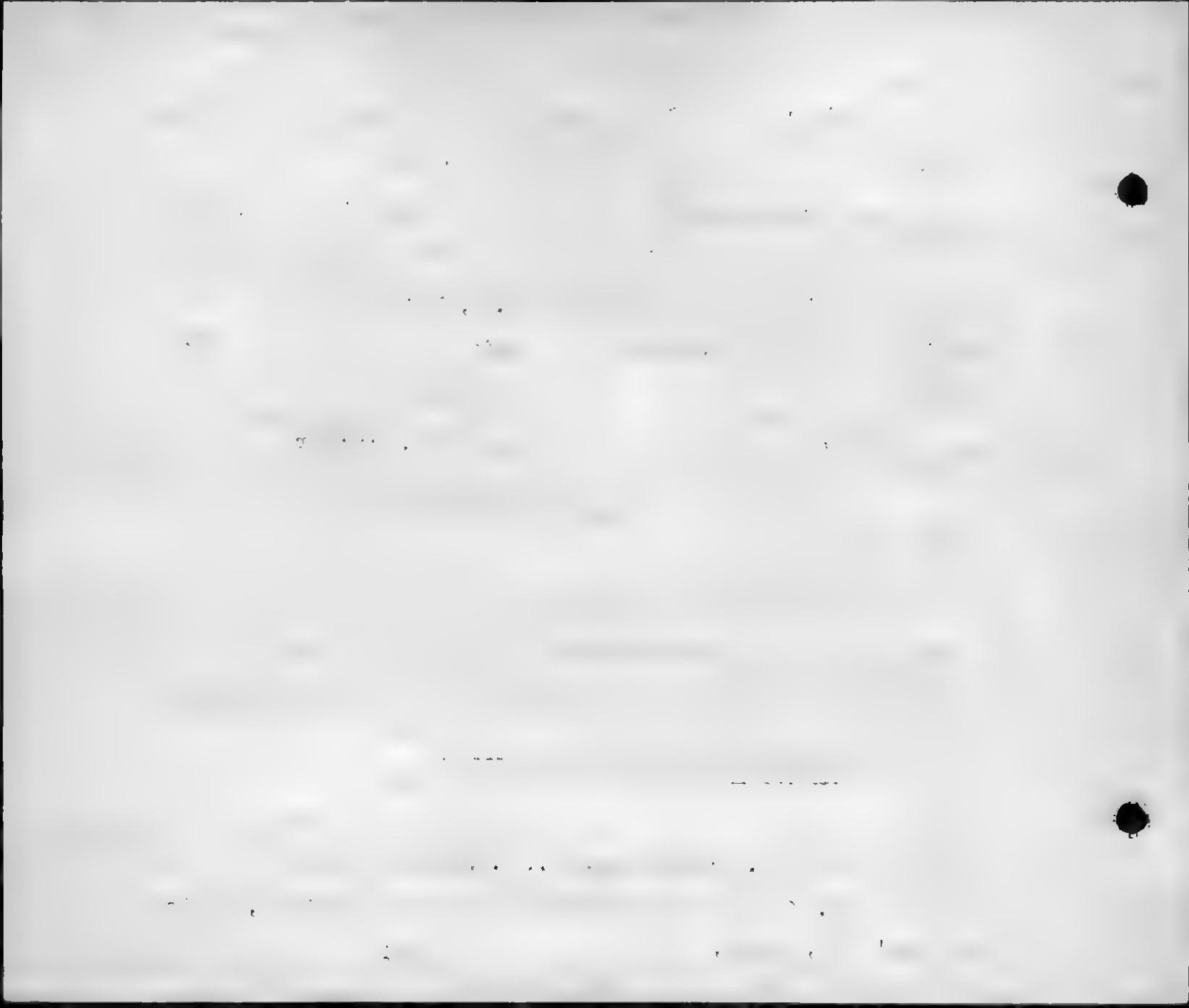
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00344

1. PLACE OF DEATH a. COUNTY  Baltimore	0361	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admis'sn) a. STATE Maryland	b. COUNTY Baltimore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate lim's, write RURAL and give nearest town) Towson	d. STREET ADDRESS 513 Fairmount Avenue	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 513 Fairmount Avenue				Month Day Year January 26 1960
3. NAME OF DECEASED (Type or print) ESTER White	First Middle Last	4. DATE OF DEATH McNeave Feb. 7, 1895	5. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1895	12. C.TIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Ohio		
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) I (If yes give war or dates of service) No None	16. SOCIAL SECURITY NO.	17. INFORMANT Frances Snyder, daughter	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous intracerebral hemorrhage with rupture into ventricular system DUE TO Conditions, if any, which gave rise to immediate cause (b). (c). DUE TO cause lost.				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)				
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER W. Bradley King, Jr., M.D. EXAMINER'S NAME (Type)	ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> M.D. DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED 1/27/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Jan. 28, 1960	22c. NAME OF CEMETERY OR CREMATORIAL ADDRESS (Street, city, town, or county) Baltimore National Cemetery Baltimore, Maryland	22d. LOCATION (City, town, or country) (State)	
23. FUNERAL DIRECTOR John Burns' Sons, Towson, Maryland	ADDRESS	24a. REC'D BY REGISTRAR FEB 2 '60	24b. REGISTRAR'S SIGNATURE C. Burns & Sons	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00345

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colgate				
d NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7826b Eastern Ave.		d STREET ADDRESS 7826 Eastern Ave.	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SOPHIA	First C.	Middle MOFFETT	4. DATE OF DEATH January 3, 1960			
5. SEX Female	6. COLOR OR RACE White	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 7, 1874			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland			
		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry C. Knorr		14. MOTHER'S MAIDEN NAME Caroline Leech				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	17. INFORMANT Mrs. Mary Kemp 7826 Eastern Ave-24 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Thrombosis</i> DUE TO (c) <i>arterio - sclerosis</i> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						
INTERVAL BETWEEN ONSET AND DEATH 1 day						
6 months						
.5 years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Baltimore	(State) Md.
21. I certify that I attended the deceased from <i>May 1956</i> to <i>Jan 3 1960</i> that I last saw the deceased alive on <i>Jan 2 1960</i> , and that death occurred at <i>Baltimore</i> M. from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Morris A. Jacobs</i> ADDRESS (Street, city or town, state) <i>1010 North Point Rd.</i> DATE SIGNED <i>1/14/60</i>						
PHYSICIAN'S NAME (Type) <i>Morris A. Jacobs</i> <i>Baltimore</i> <i>Jan 24 1960</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/6/60	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery	22d. LOCATION (City, town, or county) Baltimore, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.				24a. REC'D BY REGISTRAR JAN 5 '60	24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>	



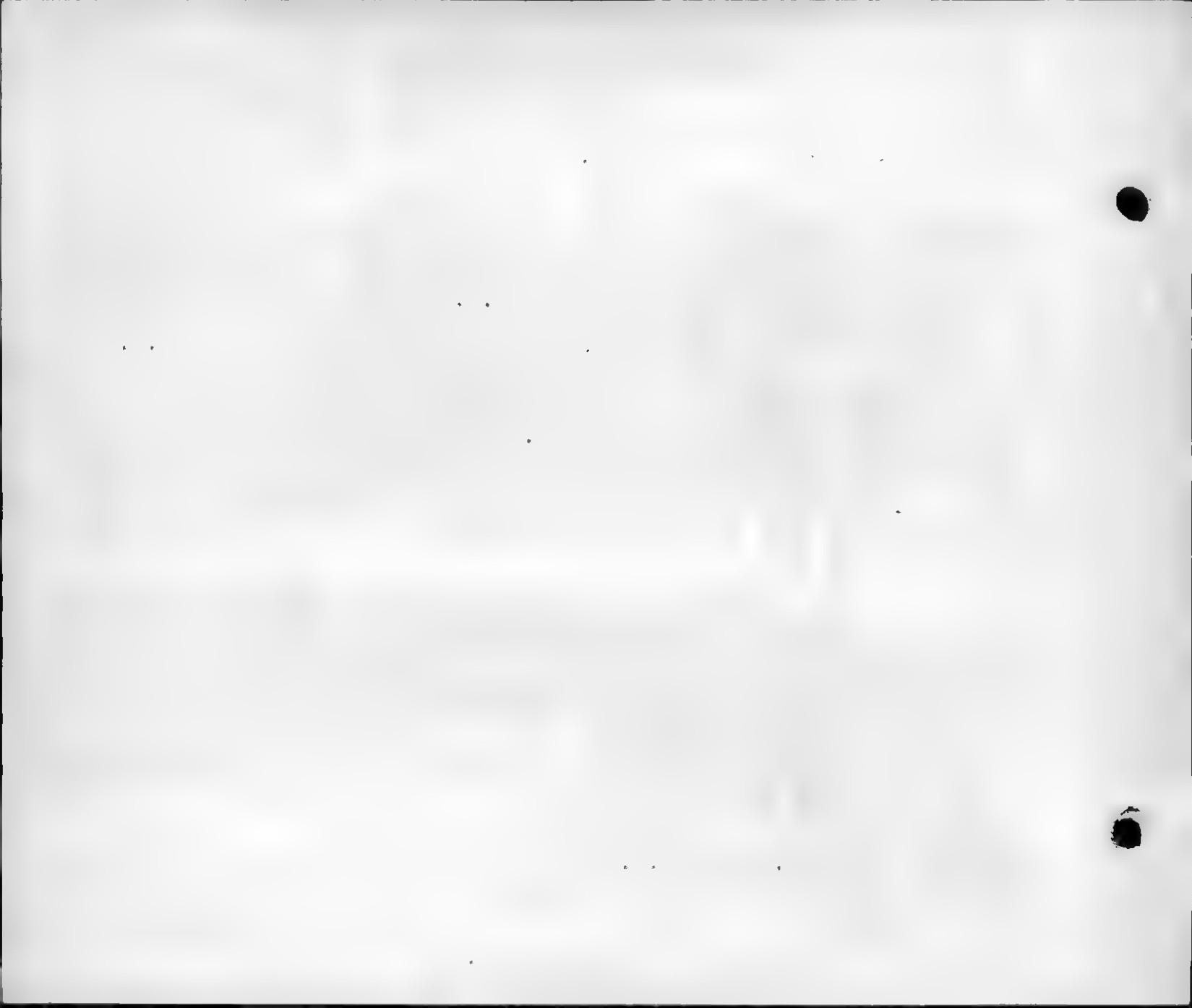
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0222 CERTIFICATE OF DEATH

01346

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		c. LENGTH OF STAY IN lb <b>25 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk (22)</b>		d. STREET ADDRESS <b>8 Arrowship Road</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8 Arrowship Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>ELIZABETH</b>		First <b>ELIZABETH</b>	Middle <b>++++</b>	Last <b>MORGAN</b>	4. DATE OF DEATH <b>January 25th, 1960</b>	Month <b>January</b>	Day <b>25</b>	Year <b>1960</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 6, 1867</b>		9. AGE (in years last birthday) <b>92</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grocery</b>		11. BIRTHPLACE (State or foreign country) <b>Swansea, South Wales</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John Walters</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Morgan</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mrs. Margaret Thomas</b>		Address <b>same as #2</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage.</b> DUE TO <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>351X -</b>		(b) DUE TO <b>Arteriosclerosis</b>		(c)						<b>10 years.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. p.m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dundalk</b>		(County) <b>Baltimore</b>	(State) <b>Maryland</b>		
21. I certify that I attended the deceased from <b>Jan. 19, 1953</b> , to <b>Jan 25, 1960</b> , that I last saw the deceased alive on <b>Jan 25, 1960</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>33 Dundalk Avenue</b>	DATE SIGNED <b>1/26/60</b>
ACTUAL SIGNATURE <i>David H. Andrew</i>		M.D.									
PHYSICIAN'S NAME (Type) <b>David H. Andrew, M.D.</b>		Baltimore 22, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Oakwood Cemetery</b>		22d. LOCATION (City, town, or county) <b>Sharon, Pennsylvania</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter Brooks Bradley</i>		ADDRESS <b>Dundalk 22, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 28 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Charles S. Trahan</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARXLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

06347

1. PLACE OF DEATH a. COUNTY <i>Rosewood State Training School Baltimore Maryland</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) b. STATE <i>MARYland Montgomery 15</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings Mills M.D. 6 years home.</i>		c. LENGTH OF STAY IN 1b <i>6 years home.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Rosewood State Training School</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring Maryland</i>	
d. STREET ADDRESS <i>4307 GARROTT PARK RD.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>PATRICIA</i>	Middle <i>Eileen</i>	Last <i>Mosher</i>
4. DATE OF DEATH	Month <i>1 - 24</i>	Day <i>1960</i>	Year
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-50</i>
9. AGE (In years last birthday) <i>9 yrs</i>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Child</i>	11. KIND OF BUSINESS OR INDUSTRY <i>-----</i>	12. BIRTHPLACE (State or foreign country) <i>Istanbul, Turkey</i>
13. FATHER'S NAME <i>Bernard Mosher</i>	14. MOTHER'S MAIDEN NAME <i>MAUREE n BERNADETTE Frawley</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>	16. SOCIAL SECURITY NO. <i>-----</i>	INFORMANT <i>Bernard Mosher-father-same as 2d</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>500x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>(b)</i> DUE TO <i>(c)</i> Broncho-Pneumonitis Acute Bronchitis			
INTERVAL BETWEEN ONSET AND DEATH <i>Two weeks</i> <i>Two weeks</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Symptoms of Migraine Epilepsy</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. Enter nature of injury in Part I or Part II of item 18.) <i>-----</i>	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 23, 1960, to Jan 24, 1960, that I last saw the deceased alive on Jan 24, 1960, and that death occurred at 12 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Harry G. Boteler</i>	M.D.		ADDRESS (Street, city or town, state) <i>Owings Mills, Md 24 Jan 60</i>
PHYSICIAN'S NAME (Type) <i>Harry G. Boteler</i>	DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1/26/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Parklawn Cemetery</i>	22d. LOCATION (City, town, or county) <i>Rockville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Robert A. Pumphrey</i>	ADDRESS <i>Bethesda, Maryland</i>	24a. REC'D BY REGISTRAR DATE JAN 26 '60	24b. REGISTRAR'S SIGNATURE <i>in my office</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please have carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58



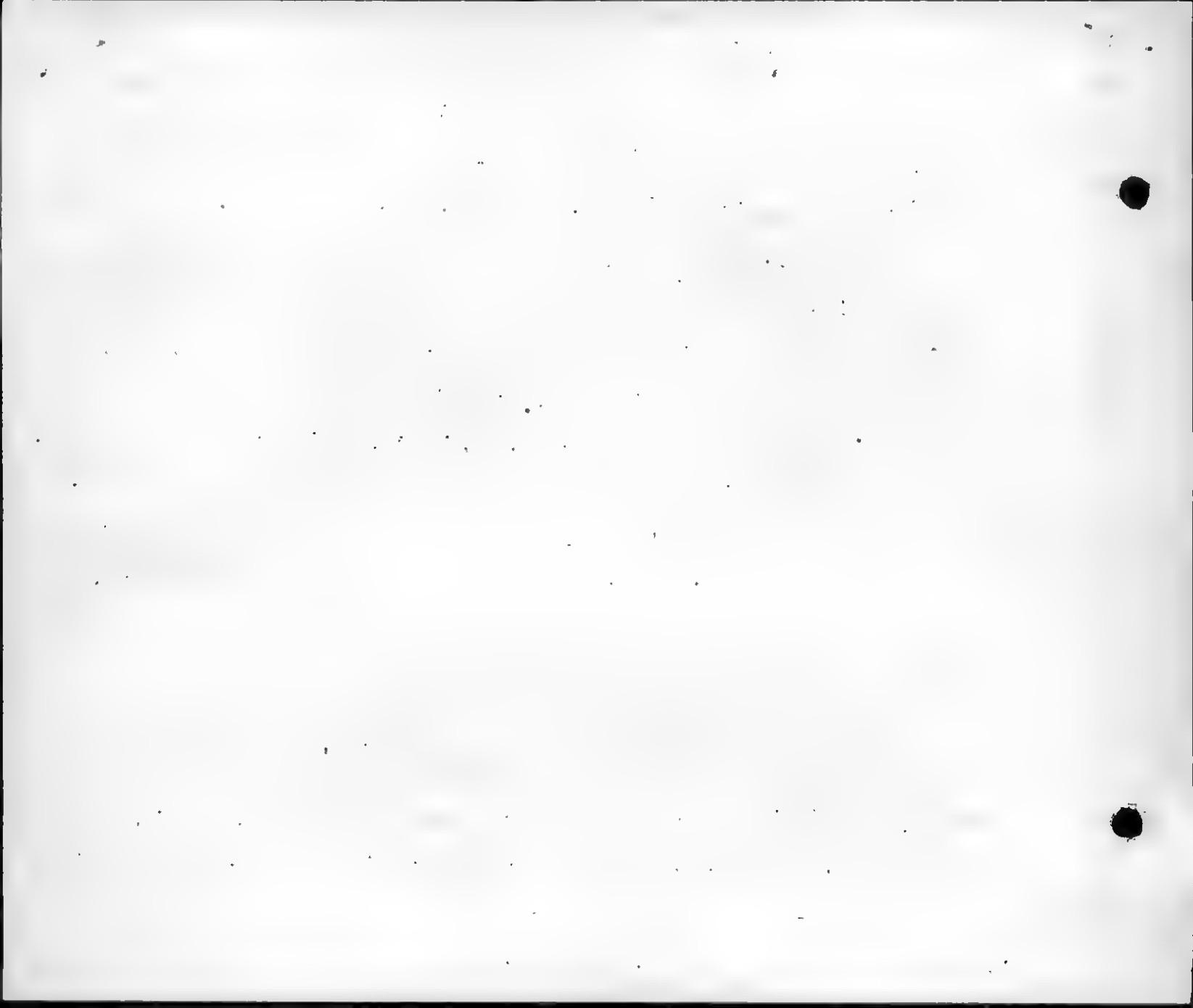
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00348

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>1</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>55 Min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellicott City</b>		d. STREET ADDRESS <b>292 W. Main Street</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JOHN</b>		First <b>L.</b>	Middle <b>MURK</b>	4. DATE OF DEATH <b>January 5 1960</b>	Month <b>January</b>	Day <b>5</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1919</b>	9. AGE (In years last birthday) <b>40 yrs</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Catonsville, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Edward Murk</b>		14. MOTHER'S MAIDEN NAME <b>Aura Affeldt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-10-7333</b>		INFORMANT <b>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</b>	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC COMA</b>							
581.1 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LAENNEC'S CIRRHOSIS</b>							
DUE TO							
(c) <b>EDEMA OF LUNGS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTO. 18, MD. FORT HOWARD DIV.</b>		20f. (City or town) (County) (State)	
21. I certify that X attended the deceased from <b>3:00 AM 1/5, 1960</b> , to <b>2:05 PM 1/5, 1960</b> , <b>VAH, BALTO. 18, MD. FORT HOWARD DIV.</b> and that death occurred at <b>2:05 P.M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>John W. Crawford</b>							
DATE SIGNED <b>1/6/60</b>							
ACTUAL SIGNATURE <b>John W. Crawford</b>							
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>							
VAH, Baltimore 18, Md. Ft. Howard Div 1/6/60							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-8-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Gem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. C. Higinbotham, 106 Columbia R., Ellicott Cy. Md.</b>		ADDRESS <b>Ellicott Cy. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Thomas</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

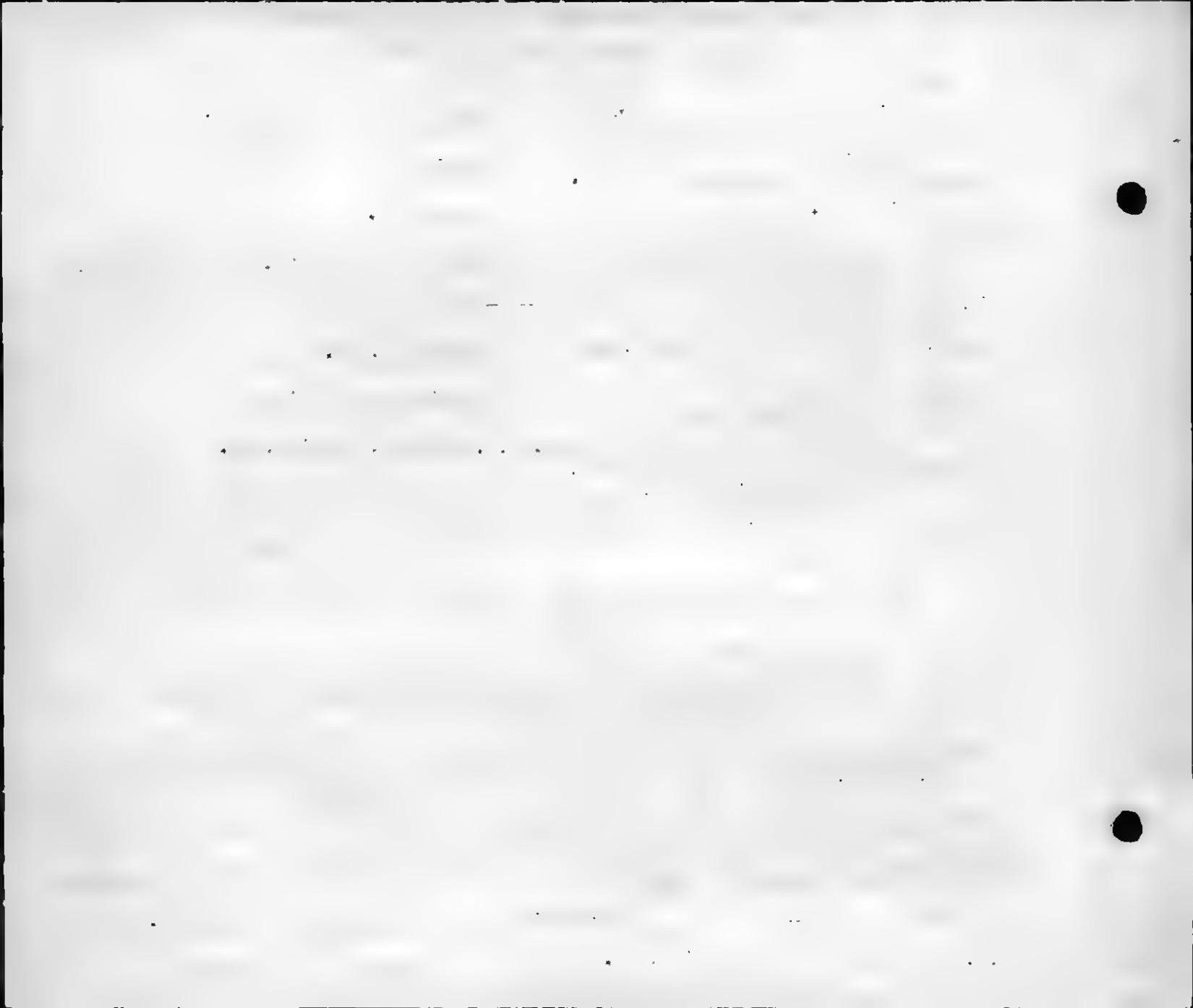
0365

## CERTIFICATE OF DEATH

Reg. Dist. No.

00349

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		c. LENGTH OF STAY IN 1b <b>Acme Ave.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Granite</b>		d. STREET ADDRESS <b>Acme Ave.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Acme Ave.</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JACOB</b>	Middle <b>THOMAS</b>	Last <b>NASH</b>	4. DATE OF DEATH <b>Jan. 23</b>	Month <b>Jan.</b>	Day <b>23</b>	Year <b>1960</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>5-13-1866</b>	9. AGE (In years lost birthday) <b>93</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stone cutter</b>		11. BIRTHPLACE (State or foreign country) <b>Woodstock, Md.</b>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <b>Joseph H Nash</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Jane Albright</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>Mrs. F.L.Brantley, Granite, Md.</b>		Address			
no		none							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Cardiovascular Disease</b> DUE TO (c)									
INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rundalltown</b>		20f. (City or town) <b>Md.</b>		(County) <b>Maryland</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on <b>Jan. 13, 1960</b> , and that death occurred at <b>M.</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Tom E. Martin</b>		ADDRESS (Street, city or town, state) <b>Rundalltown Md.</b>							DATE SIGNED <b>1/27/60</b>
PHYSICIAN'S NAME (Type) <b>Tom E. Martin</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-26-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Presbyterian</b>		22d. LOCATION (City, town, or county) <b>Granite</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham</b>		ADDRESS <b>Ellicott City, Md.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Knapp</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knapp</b>			
VS. A15 (4) 15M 9/55				DATE <b>JAN 27 '60</b>					



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(00350)

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Reg. Dist. No.														
1. PLACE OF DEATH a. COUNTY				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) b. STATE										
<i>Baltimore</i>				<i>MARYLAND</i>				<i>Md.</i>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)						
<i>Gibsonville</i>				<i>Life</i>				<i>Gibsonville</i>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS				e. S. RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
<i>509 Reisterstown Road</i>				<i>509 Reisterstown Rd.</i>										
3. NAME OF DECEASED (Type or print)		First	Middle	4. DATE OF DEATH		Month	Day	Year						
<i>Charles J. Naylor</i>				<i>Jan.</i>		<i>Jan.</i>	<i>6</i>	<i>1960</i>						
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years less birthday)		10. IF UNDER 1 YEAR Months Days			11. IF UNDER 24 HRS Hours Min.			
<i>M.</i>		<i>W.</i>	<i>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></i>	<i>Jan 1, 1872 88</i>		<i>yrs.</i>		<i>0 5</i>						
10a. USUAL OCCUPATION (Give kind of work done during most of working-life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?		
<i>Retired Plasterer</i>				<i>Plastering</i>				<i>Maryland</i>				<i>N. S. A.</i>		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME										
<i>Unknown</i>				<i>Unknown</i>										
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or Unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT				Address		
<i>No</i>				<i>none</i>				<i>Mr Robert E. Miller</i>				<i>509 Reisterstown Rd.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]												INTERVAL BETWEEN CINSE AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												<i>5 yrs</i>		
DUE TO <i>Arteriosclerotic G-V disease</i>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														
DUE TO <i>Fractured Rt. Hip.</i>														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)										
				<i>Fell at home &amp; broke hip.</i>										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>				20f. (City or town) <i>Gibsonville</i>	(County) <i>Baltimore</i>	(State) <i>Md.</i>
<i>Feb 22 1959</i>														
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												DATE SIGNED <i>1-8-60</i>		
ACTUAL SIGNATURE <i>D. D. Caples</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
NAME (Type) <i>D. D. CAPLES</i>				M.D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				22b. DATE THEREOF <i>1/9/60</i>				22c. NAME OF CEMETERY OR CREMATORIAL <i>Druid Ridge</i>				22d. LOCATION (City, town, or county) <i>Baltimore</i>		
												(State) <i>Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Loring Byers</i>				ADDRESS <i>8728 Liberty Rd. Reisterstown, Md.</i>				24a. REC'D BY REGISTRAR <i>Cuthbert S. Krause</i>				24b. REGISTRAR'S SIGNATURE		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0363

## CERTIFICATE OF DEATH

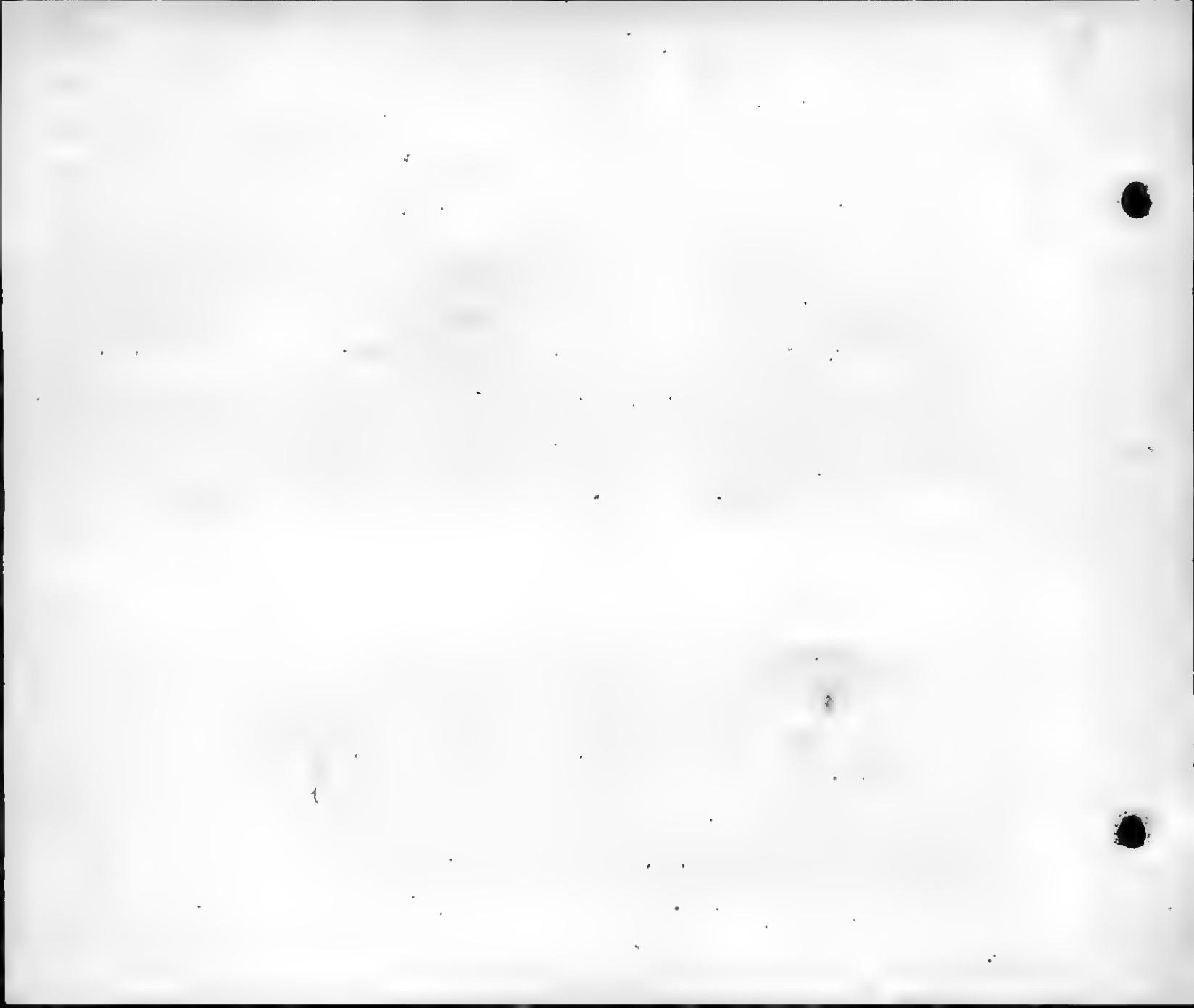
Reg. Dist. No.

00351

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore MARYLAND</b>		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>1mth22dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bladensburg, Maryland</b>	
3. NAME OF DECEASED (Type or print) <b>Rollie</b>		4. DATE OF DEATH <b>JANUARY 30 1960</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown Hoisting Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
10c. BIRTHPLACE (State or foreign country) <b>Maryland Nebraska</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Nebraska U. S. A.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Unknown Henry Neifert</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown Elizabeth Clatterbuck</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <b>yes</b>	
16. SOCIAL SECURITY NO. <b>C20 84 27 48</b>		INFORMANT Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH [Enter only ONE cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple metastases due to bronchogenic carcinoma</b> <b>162.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>of the left lung</b> DUE TO DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Dec. 16, 1959</b> , to <b>Jan. 20, 1960</b> (County) <b>1-20-60</b> (State)	
21. I certify that I attended the deceased from <b>Dec. 16, 1959</b> , to <b>Jan. 20, 1960</b> , that I last saw the deceased alive on <b>Jan. 20, 1960</b> , and that death occurred at <b>6:45a M</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Stella Wachler</b> M.D. DATE SIGNED <b>Spring Grove State Hospital 1-20-60</b>	
ACTUAL SIGNATURE <b>Stella Wachler</b>		PHYSICIAN'S NAME (Type) <b>Stella Wachler, M. D.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL Jan 25, 1960</b>		22b. DATE THEREOF <b>APRIL 25, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Arlington National</b>		22d. LOCATION (City, town, or county) <b>FT. MYER, DC</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Chambers Co. Inc.</b>		ADDRESS <b>1400 Elgin St NW</b>	
		24a. REC'D BY REGISTRAR <b>DALE 27 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



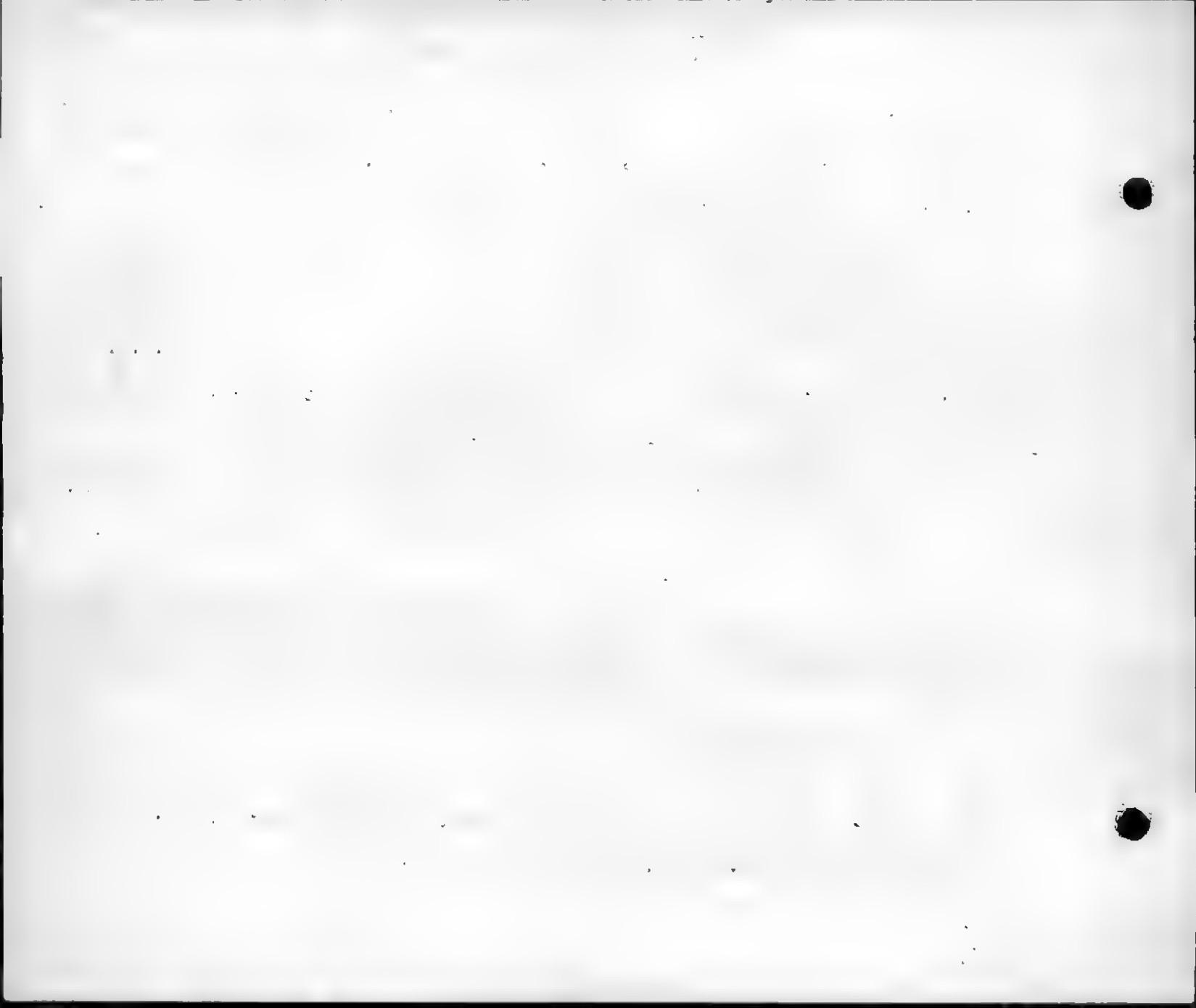
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0368 CERTIFICATE OF DEATH

Reg. Dist. No.

00352

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cdings Hills, Maryland		c. LENGTH OF STAY IN 1b 1 yr, 10 mos.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rosewood State Training School		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lippie		First Niemeyer	Middle Niemeyer
4. DATE OF DEATH 1		Month 25	Day 19
5. SEX Female White		6. COLOR OR RACE WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
8. DATE OF BIRTH 2/10/39		9. AGE (in years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months Days Hours Min
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Henry Niemeyer - deceased		14. MOTHER'S MAIDEN NAME Mary Catherine Mamberger - deceased	
15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. INDEMNITY Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Acute respiratory disease</u>			
INTERVAL BETWEEN ONSET AND DEATH 1 hr.			
24 yrs.			
12 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March 5, 1958</u> , to <u>January 25, 1960</u> , that I last saw the deceased alive on <u>January 25, 1960</u> , and that death occurred at <u>12 noon</u> , M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Edward J. Matthews</u>		M.D. Rosewood State Training School	
PHYSICIAN'S NAME (Type) <u>Edward J. Matthews, M.D.</u>		Orings Hills, Maryland	
22a. BURIAL OR REMANENT REMOVAL (Specify)		22b. DATE THEREOF <u>Jan. 28, 60</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Oak Lawn</u>
22d. LOCATION (City, town, or county) <u>BALTIMORE</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Thorne</u>		24a. REC'D BY REGISTRAR DATE JAN 28 '60	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thorne</u>
ADDRESS <u>6067 Harford Rd</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

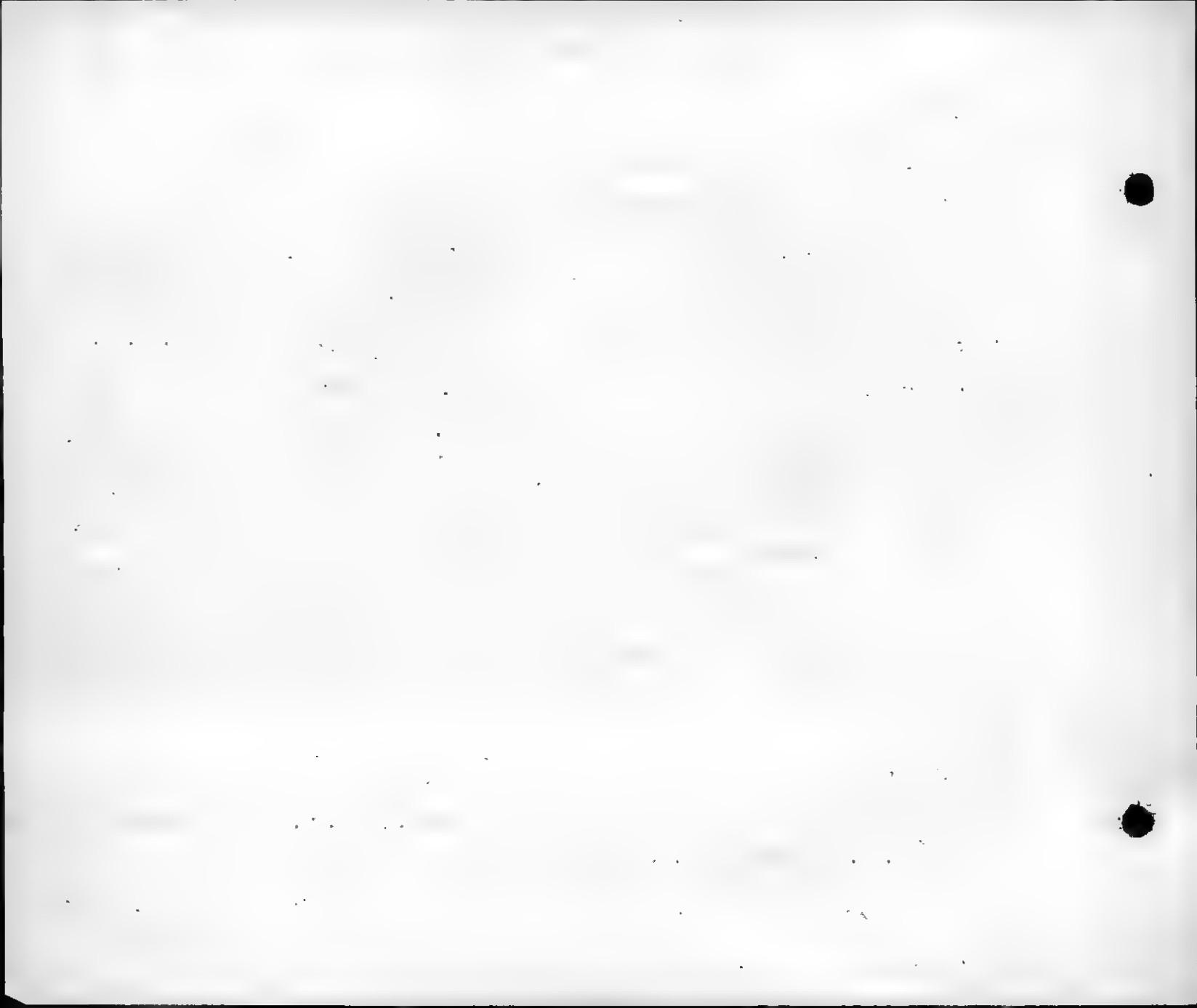
## 03C9 CERTIFICATE OF DEATH

Reg. Dist. No.

100353

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>21 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		(30)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. STREET ADDRESS <b>1628 Sexton Street</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle ---	Last <b>NISER</b>	4. DATE OF DEATH <b>January 19 1960</b>	Month January	Day 19	Year 1960
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 10, 1892</b>	9. AGE (In years (last birthday) yrs.) <b>67</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Philip Niser</b>		14. MOTHER'S MAIDEN NAME <b>Katherine Miller</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>213-05-9476</b>		INFORMANT <b>Clin. Records, VAH, Balto. 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA, LEFT KIDNEY</b> INTERVAL BETWEEN ONSET AND DEATH <b>UNKNOWN</b>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>THROMBOSIS OF LEFT RENAL ARTERY</b> (c) <b>UREMIA</b> UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	(County) <b>1/19/60</b>
21. I certify that I attended the deceased from December 29, 1959, to January 19, 1960, and that death occurred at 2:38 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1/19/60</b>							
DATE SIGNED <b>1/19/60</b>							
ACTUAL SIGNATURE <b>W. J. PIJANOWSKI</b>							
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Western Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>	
(State) <b>Maryland</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Toulson</b>		ADDRESS <b>2359 Washington Blvd. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Curth 2. Tolson</b>	



may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13-14 Filing 54 1-18-60 et

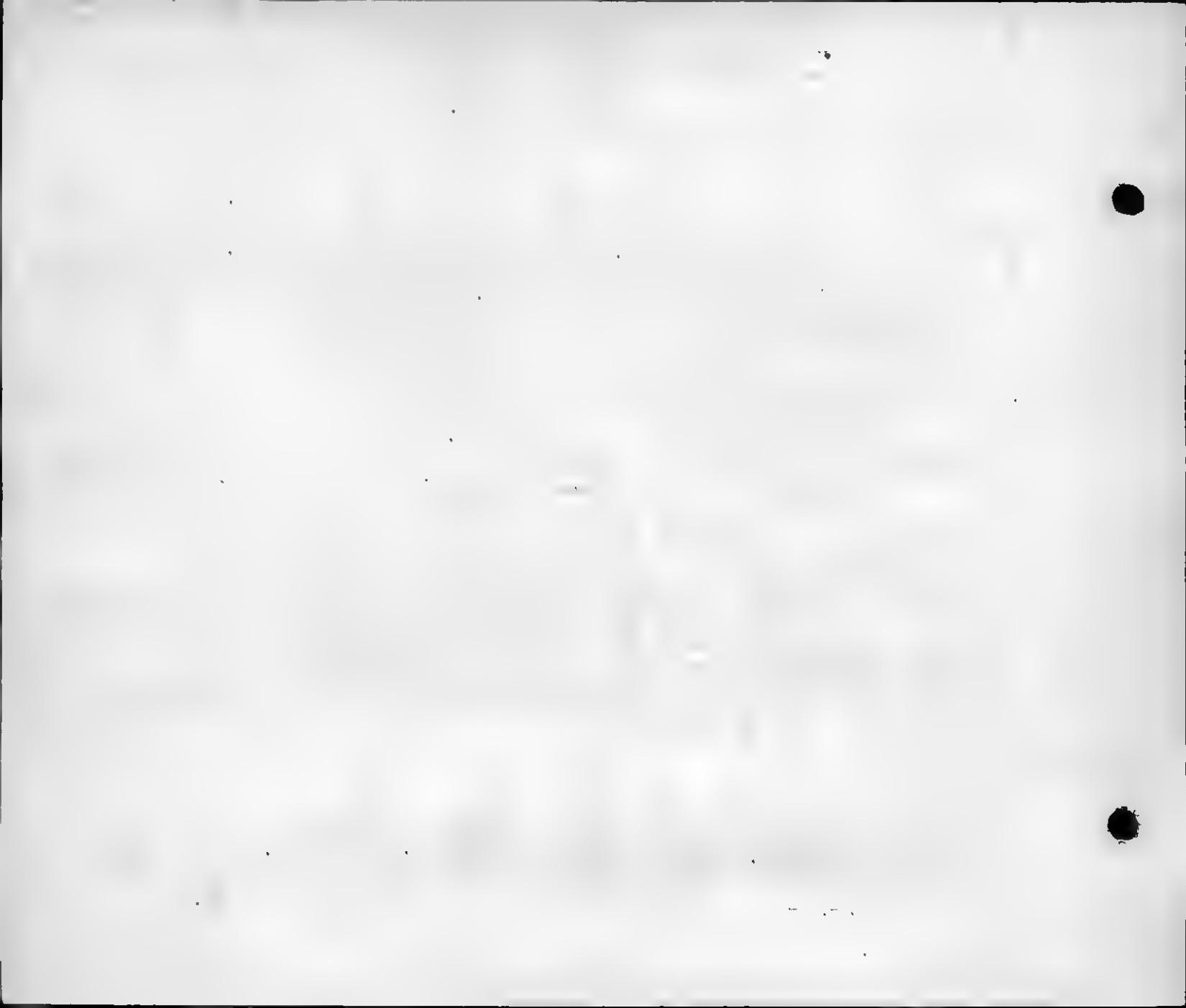
00354

0370

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Baltimore ✓</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		c. LENGTH OF STAY IN 1b <i>1b</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>St Joseph's Nursing Home</i>		d. STREET ADDRESS <i>604 Craycombe Ave.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Frank</i>	Middle <i>J.</i>	Last <i>Oberle</i>	4. DATE OF DEATH <i>Sept. 14, 1882</i>	Month <i>Jan.</i>	Day <i>10</i>	Year <i>19 60</i>
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept. 14, 1882</i>	9. AGE (In years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>77</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>jeweler</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Seraphin Oberle</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Kiedet</i>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>[Redacted]</i>		17. INFORMANT <i>Father G. Oberle</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>Hypertensive C-V Disease</i> DUE TO <i>Arteriovenous Fibrillation</i>							
INTERVAL BETWEEN ONSET AND DEATH <i>3 mos</i>							
10+ yrs							
3+ yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cardiac Failure</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>[Redacted]</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Dec 10, 1960</i> to <i>Jan 10, 1960</i> , that I last saw the deceased alive on <i>Jan 10, 1960</i> , and that death occurred at <i>9:21 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>1102 E. Joppa Rd.</i> DATE SIGNED <i>Victor F. King</i> M.D. <i>1102 E. Joppa Rd.</i> <i>1/11/60</i>							
ACTUAL SIGNATURE <i>Victor F. King</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i> 1-14-60					
PHYSICIAN'S NAME (Type) <i>Victor F. King</i>		22b. DATE THEREOF <i>1-14-60</i>					
22c. NAME OF CEMETERY OR CREMATORIAL <i>Holy Redeemer</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck 5305 Harford Rd</i>		24a. REC'D BY REGISTRAR DATE JAN 13 '60					
ADDRESS <i>5305 Harford Rd</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

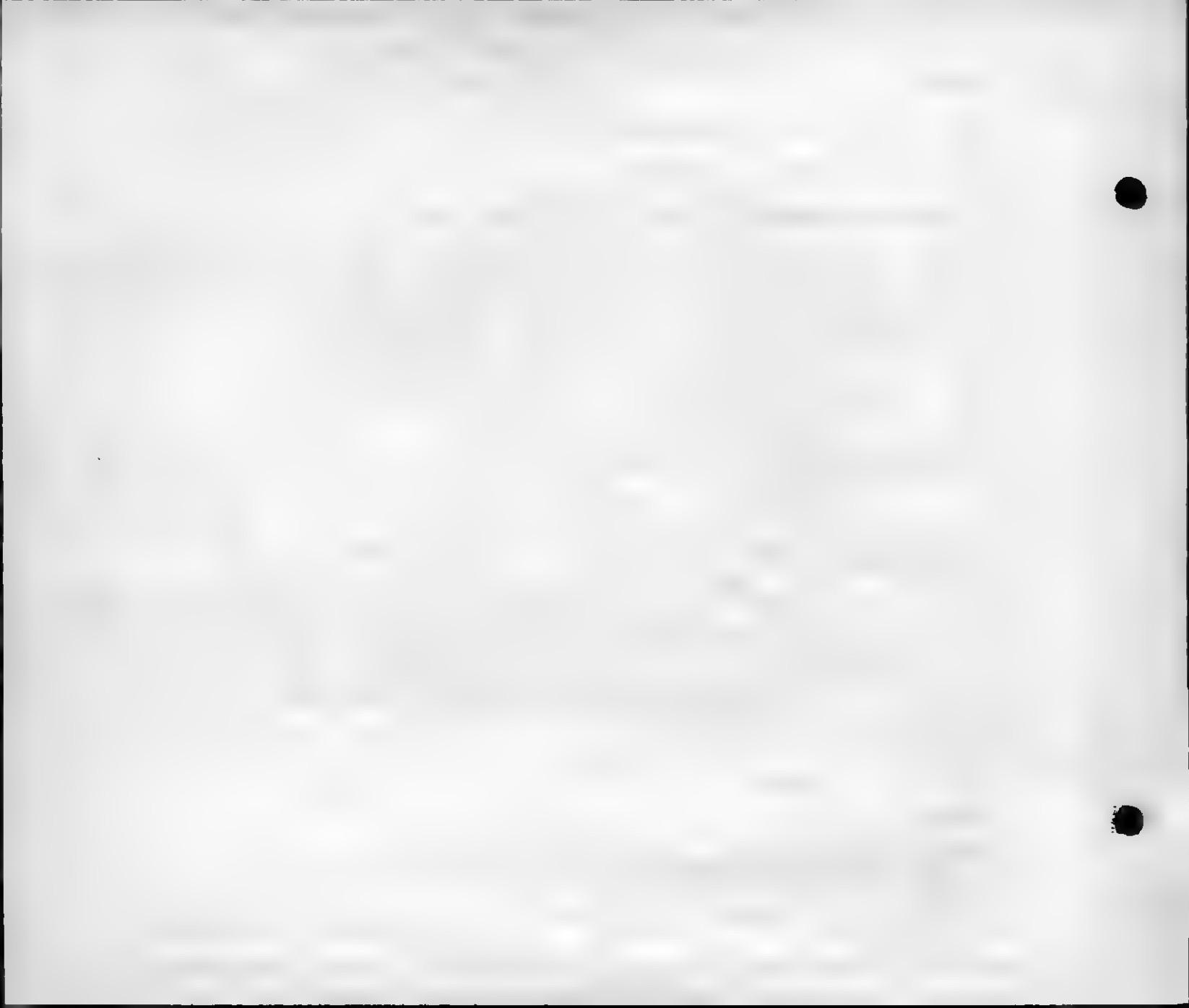
00355

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Parkville		a. STATE	MARYLAND b. COUNTY
c. LENGTH OF STAY IN 1b		2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1739 Wycliffe Ave.		x Parkville	
e. NAME OF DECEASED (Type or print)		First Anna	Middle Mary	Last O'Naughlin	4. DATE OF DEATH JAN. 1 1960
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 2-4-1889	9. AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Seamstress		Funeral Supplies		Maryland	
13. FATHER'S NAME George Aldridge		14. MOTHER'S MAIDEN NAME Elmira Barnes		12. CITIZEN OF WHAT COUNTRY? U.S.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)		16. SOCIAL SECURITY NO 213-05-4003		17. INFORMANT Mr. Everett O'Naughlin (Wycliffe as Address	
No					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction		15 hrs.			
DUE TO					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease		11 mos.			
DUE TO					
(c) Squamous carcinoma of uterine cervix		11 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
see "C", part I					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 18, 1959, to January 1, 1960, that I last saw the deceased alive on January 1, 1960, and that death occurred at 3:40 A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Roy W. Cheaney, Jr. M.D.		251st Pennsylvania Ave.			
PHYSICIAN'S NAME (Type) Roy W. Cheaney, Jr.		Towson 4, 17d.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan 4, 1960		22c. NAME OF CEMETERY OR CREMATORIAL Church of God	
22d. LOCATION (City, town, or county) Winfield, Carroll, Md. (State)					
23. FUNERAL DIRECTOR'S SIGNATURE C. M. Waltz		ADDRESS Winfield, Md.		24a. REC'D BY REGISTRAR JAN 5 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. ...	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the Burial-Tombstone Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0372 CERTIFICATE OF DEATH

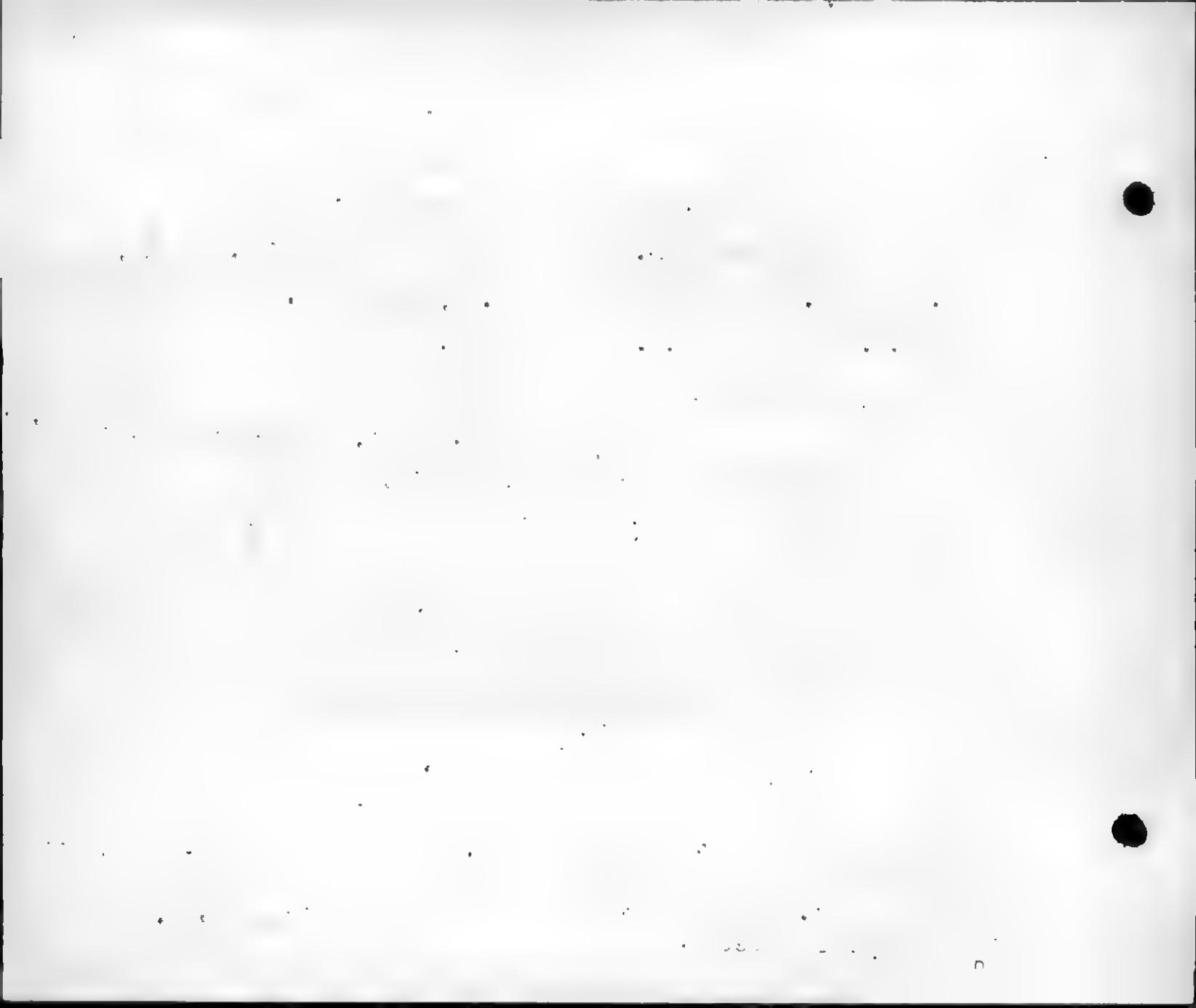
Reg. Dist. No.

00356

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

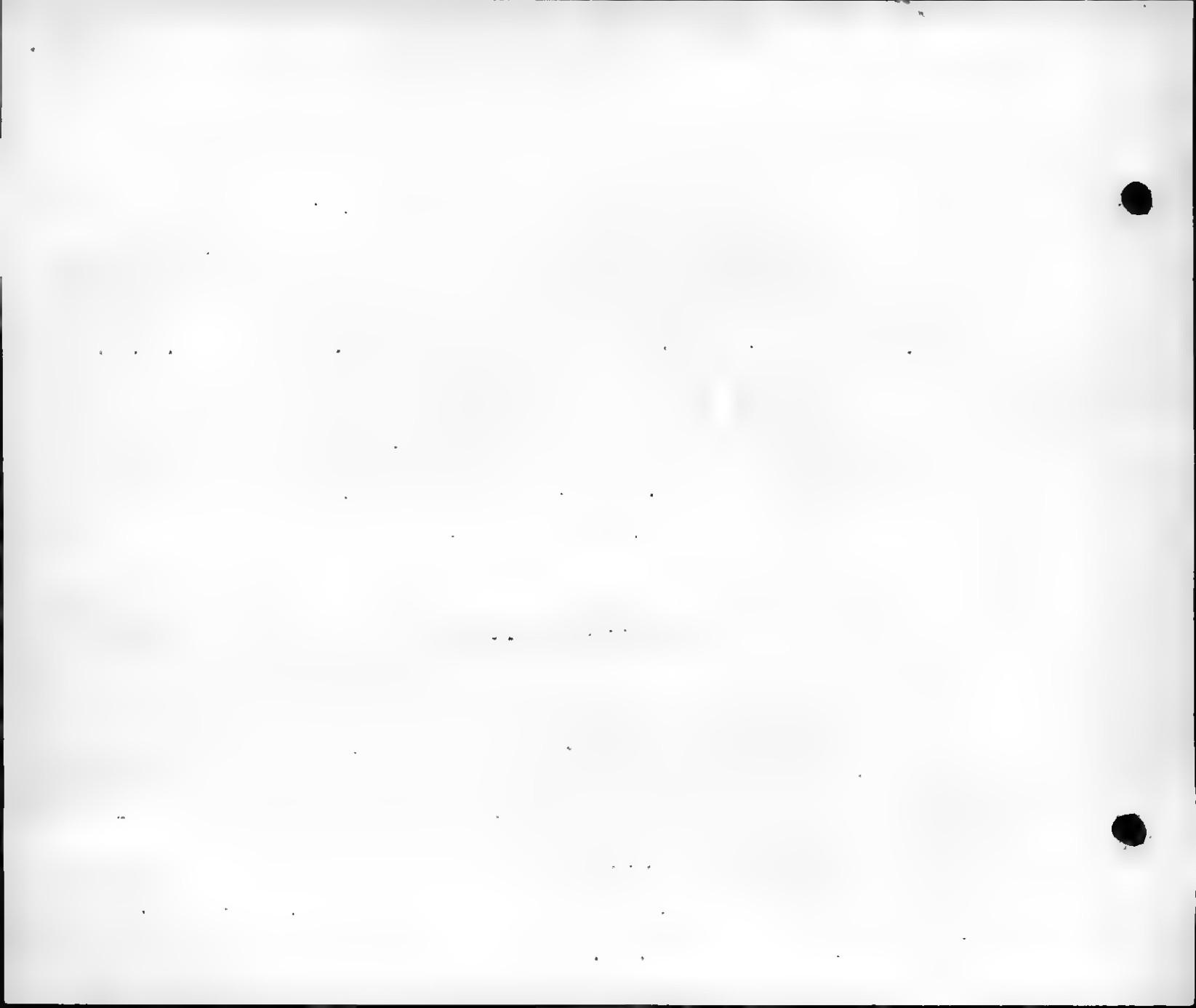
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb 52	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Summit Nursing Home</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	
3. NAME OF DECEASED (Type or print) <b>Mildred L. Ostrom</b>		First <b>Mildred</b>	Middle <b>L.</b>
4. DATE OF DEATH <b>Jan. 10, 1960</b>		Last <b>Ostrom</b>	Month Day Year
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 29, 1888</b>
9. AGE (In years last birthday) <b>71 yrs.</b>		10. IF UNDER 1 YEAR <b>Months Days Hours Min</b>	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>H.W.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>O.H.</b>	11. BIRTHPLACE (State or foreign country) <b>Pa.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Michael Gardner</b>	
14. MOTHER'S MAIDEN NAME <b>Anna</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>INFORMANT</b>		17. ADDRESS <b>Oscar E. Ostrom, 207 Glenmore Ave Catonsville, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  14X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Anemia; Decubitus Ulcer; Dehydration</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>1953</b>	
20f. (City or town) <b>1/9/60</b>		(County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>1303 Frederick Rd</b>	
ACTUAL SIGNATURE <b>W.E. McGrath</b>		DATE SIGNED <b>1/11/60</b>	
PHYSICIAN'S NAME (Type) <b>W.E. McGrath</b>		22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	
22b. DATE THEREOF <b>Jan. 12/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Woodlawn</b>	
22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Witzke Funeral Directors</b>		24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	
ADDRESS <b>Almondson San 4</b>		24b. REGISTRAR'S SIGNATURE <b>John J. Walsh</b>	
DATE			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 0373 CERTIFICATE OF DEATH												Reg. Dist. No. 00357		
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel ✓								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 2yr8mth12dys			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn, Maryland			d. STREET ADDRESS 5315 Fourth Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL														
3. NAME OF DECEASED (Type or print)		First Mattie		Middle Elizabeth		Last Oursler		4. DATE OF DEATH		Month January	Day 19	Year 1960		
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1883		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) weaver			10b. KIND OF BUSINESS OR INDUSTRY wo den mill			11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Samuel Orem						14. MOTHER'S MAIDEN NAME Alice								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) Unknown			16. SOCIAL SECURITY NO. Unknown			INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus												INTERVAL BETWEEN ONSET AND DEATH		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour a. m. p. m. 19			20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>			20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Dec. 29, 1959, to Jan. 19, 1960, that I last saw the deceased alive on Jan. 19, 1960, and that death occurred at 2:50 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Stella Wachsler M.D. SPRING GROVE STATE HOSPITAL 1-19-60												DATE SIGNED		
PHYSICIAN'S NAME (Type)		Stella Wachsler, M. D.			Catonsville 28, Maryland									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/23/60		22c. NAME OF CEMETERY OR CREMATORIUM New Oakland Com.			22d. LOCATION (City, town, or county) Carroll County MD			(State)				
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Homes				ADDRESS 130 E. Fort Ave #30			24a. REC'D BY REGISTRAR DATE JAN 21 '60			24b. REGISTRAR'S SIGNATURE Charles L. Knapp				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

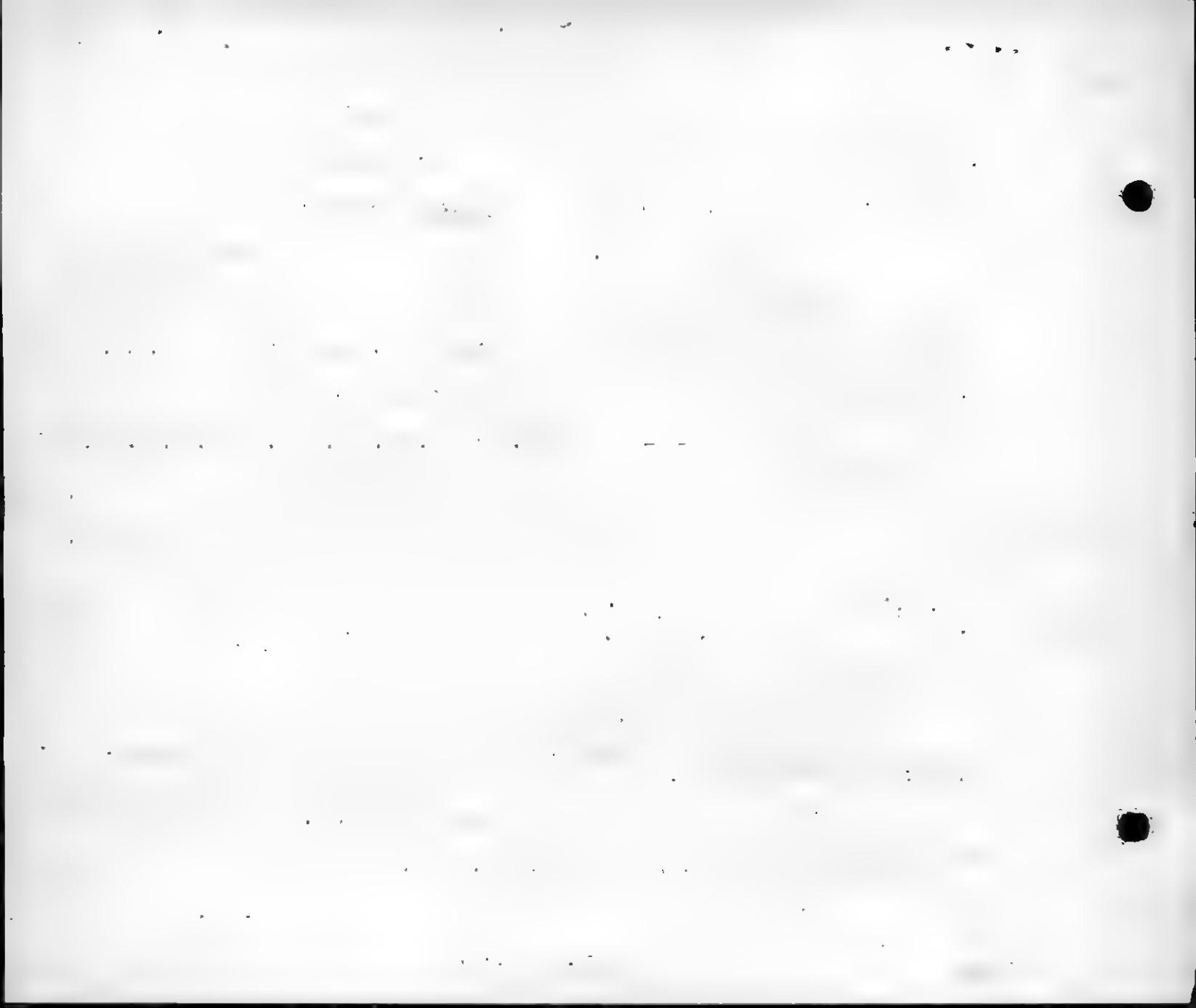
## 0374 CERTIFICATE OF DEATH

Reg. Dist. No.

00358

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission) o STATE <b>Maryland</b>		b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>4112 Reisterstown Road</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>ADOLPH</b>	Middle <b>C.</b>	Last <b>PARKENT</b>	4. DATE OF DEATH <b>January 6 1960</b>	Month <b>January</b>	Day <b>6</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/14/97</b>		9. AGE (In years last birthday) <b>62</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Plumber</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plumbing</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Parkent</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Fisher</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW I 214-34-4842</b>	INFORMANT <b>Clin. Records. Vet. Adm. Hosp. Balto. Md. Ft. Howard Div</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>180 X CARCINOMA OF BLADDER</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 YRS.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>CARCINOMA OF RENAL PELVIS, LEFT</b>						INTERVAL BETWEEN ONSET AND DEATH <b>5 1/2 YRS.</b>	
(c) DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. COND. NOT GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? <b>Operations: Ureteronephrectomy 1955. Cutaneous ureterostomy 2/2/59. Total cystectomy 2/27/59. Excision bulbous portion urethra &amp; penis, and hemorrhoidectomy</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 20a.) <b>hemorrhoidectomy</b>		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>December 29, 1959, 19 60</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VAH, BALTIMORE, MD. FT. HOWARD DIV</b>
				20f. (City or town) <b>VAH, BALTIMORE, MD. FT. HOWARD DIV</b>	(County) <b>MD.</b>	(State) <b>1/7/60</b>	
21. I certify that I attended the deceased from <b>December 29, 1959, to January 6, 1960</b> and that death occurred at <b>12:50 PM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTIMORE, MD. FT. HOWARD DIV</b> DATE SIGNED <b>1/7/60</b>							
ACTUAL SIGNATURE <i>John W. Crawford</i>							
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		VAH, BALTIMORE, MD. FT. HOWARD DIVISION 1/7/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. Vernon L. Lemonson</b>		ADDRESS <b>Fremmon Funeral Home, 1611 Park Heights Ave. Balto.</b>	24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>		



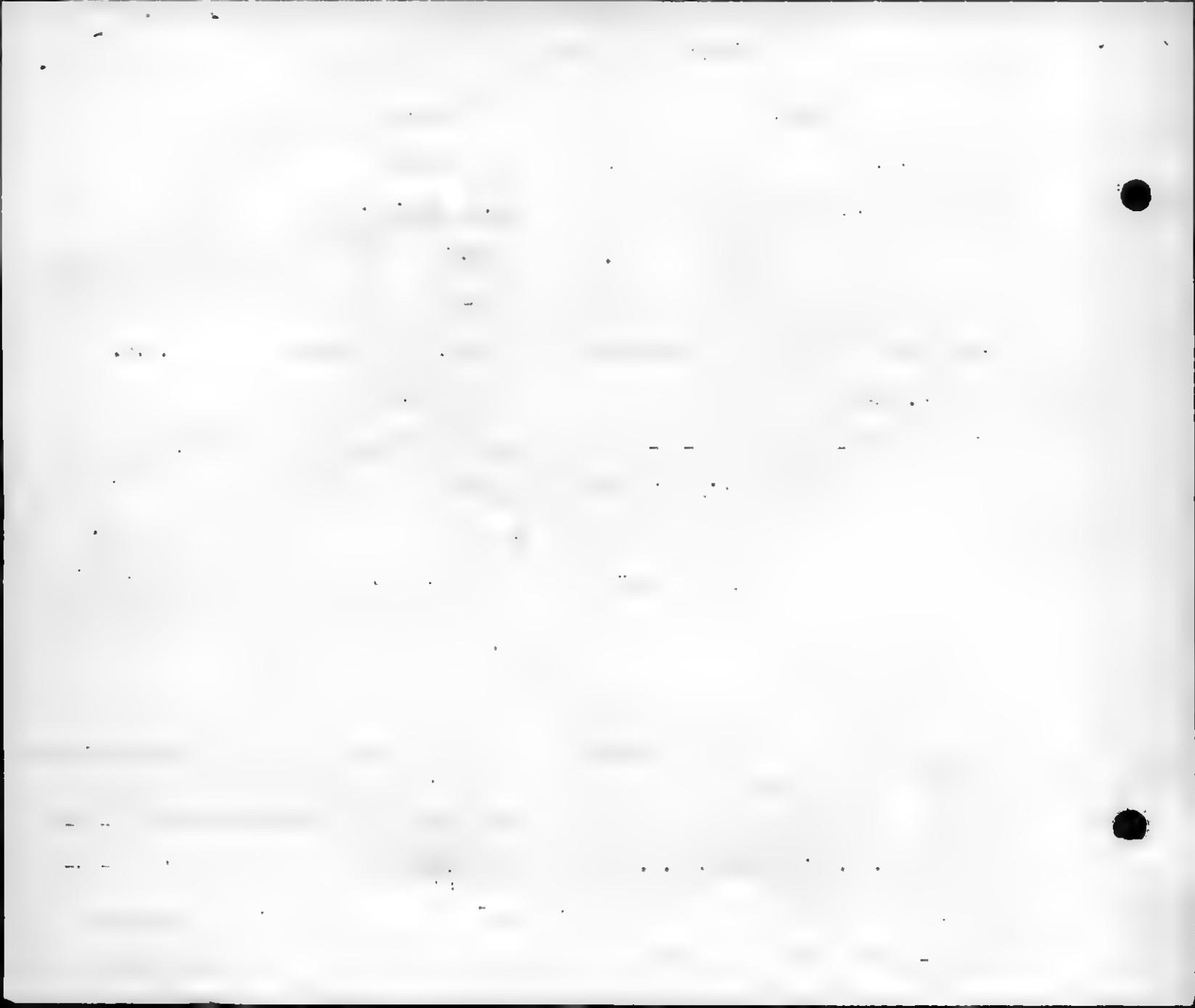
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be left with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0375 CERTIFICATE OF DEATH

Reg. Dist. No. 00350

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>16 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GEORGE</b>	Middle <b>A.</b>	Last <b>PECK</b>
4. DATE OF DEATH	Month <b>JANUARY</b>	Day <b>17</b>	Year <b>1960</b>
S. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-5-14</b>
9. AGE (In years last birthday) <b>45</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BRICKLAYER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONSTRUCTION</b>	
10c. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>IRV J. PECK</b>		14. MOTHER'S MAIDEN NAME <b>OLIVE REIL</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-10-5742</b>	
		INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>420.1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 DAYS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>ACUTE MYOCARDIAL INFARCTION</b>			
(b) <b>ACUTE CORONARY OCCLUSION</b>		2 DAYS	
(c) <b>MARKED GENERALIZED ARTERIOSCLEROSIS</b>		UNKNOWN	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>January 1, 1960</b> , to <b>January 17, 1960</b> , and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>W. J. Bijanowski</i>		ADDRESS (Street, city or town, state) DATE SIGNED <b>VAH BALTO MD FT HOWARD DIVISION 1-18-60</b>	
PHYSICIAN'S NAME (Type) <b>W. J. BIJANOWSKI, M.D.</b>		VAH BALTO MD FT HOWARD DIVISION 1-18-60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-20-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>WH COOK-BLIGHT INC 6009 Harford Rd Balto Md</b>		24a. REC'D BY REGISTRAR <b>DEIAN 20 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Virginia L. Kinsel</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0376

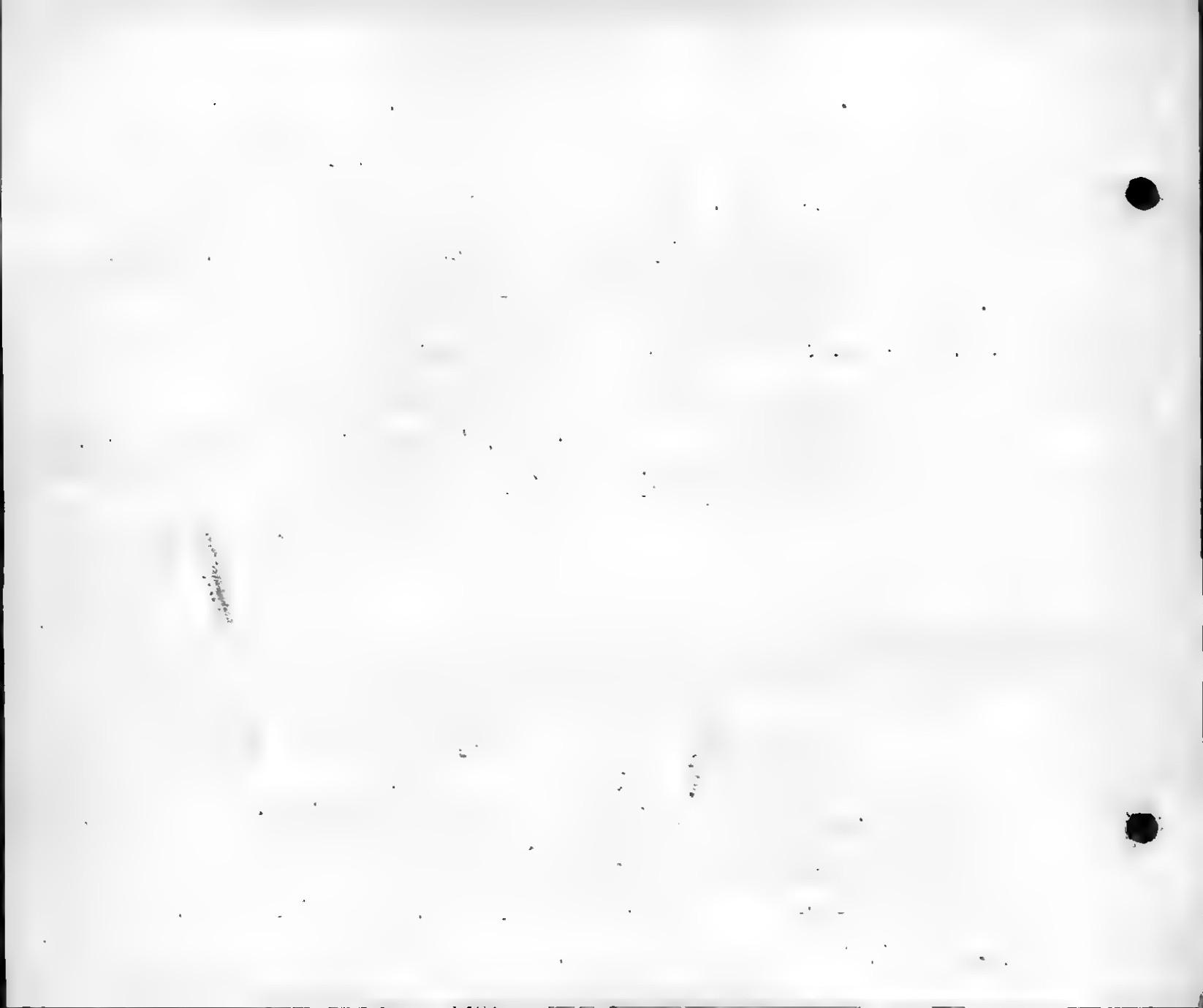
## CERTIFICATE OF DEATH

Reg. Dist. No. (00360)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE		Md.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. COUNTY Baltimore		
Towson				Baltimore		3V31-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Towson Conv. Home		d. STREET ADDRESS		2919 Christopher Ave.		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Frank		George		Petrik	Jan.	27	19	60
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 76 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Hours	Year Min
male		white		12-28-1883				
10a. USUAL OCCUPATION (Give kind of work done)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
R.R. Machinist		Navy		Maryland		USA		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME						
Frank Petrik		Barbara Kubec						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address		
(If yes, give war or dates of service)				Mrs. J. Kuehrle RFD 3 Annapolis, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Acute Cardiac Failure						
782.4		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b)						
DUE TO		(c)						
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)
19								
21. I certify that I attended the deceased from <u>Sept 20</u> , 19 <u>60</u> , to <u>Jan 27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Jan 27</u> , 19 <u>60</u> , and that death occurred on <u>Jan 27</u> , 19 <u>60</u> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED		
ACTUAL SIGNATURE		LAURENCE C. Post M.D.		6805 York Rd.		1/27/60		
PHYSICIAN'S NAME (Type)								
22a. BURIAL, CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)
burial		1-30-60		Holy Redeemer Cem.		Baltimore, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Leonard J. Ruck 5305 Harford Rd.				DATE FEB 1 '60		Clifford S. Kincaid		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

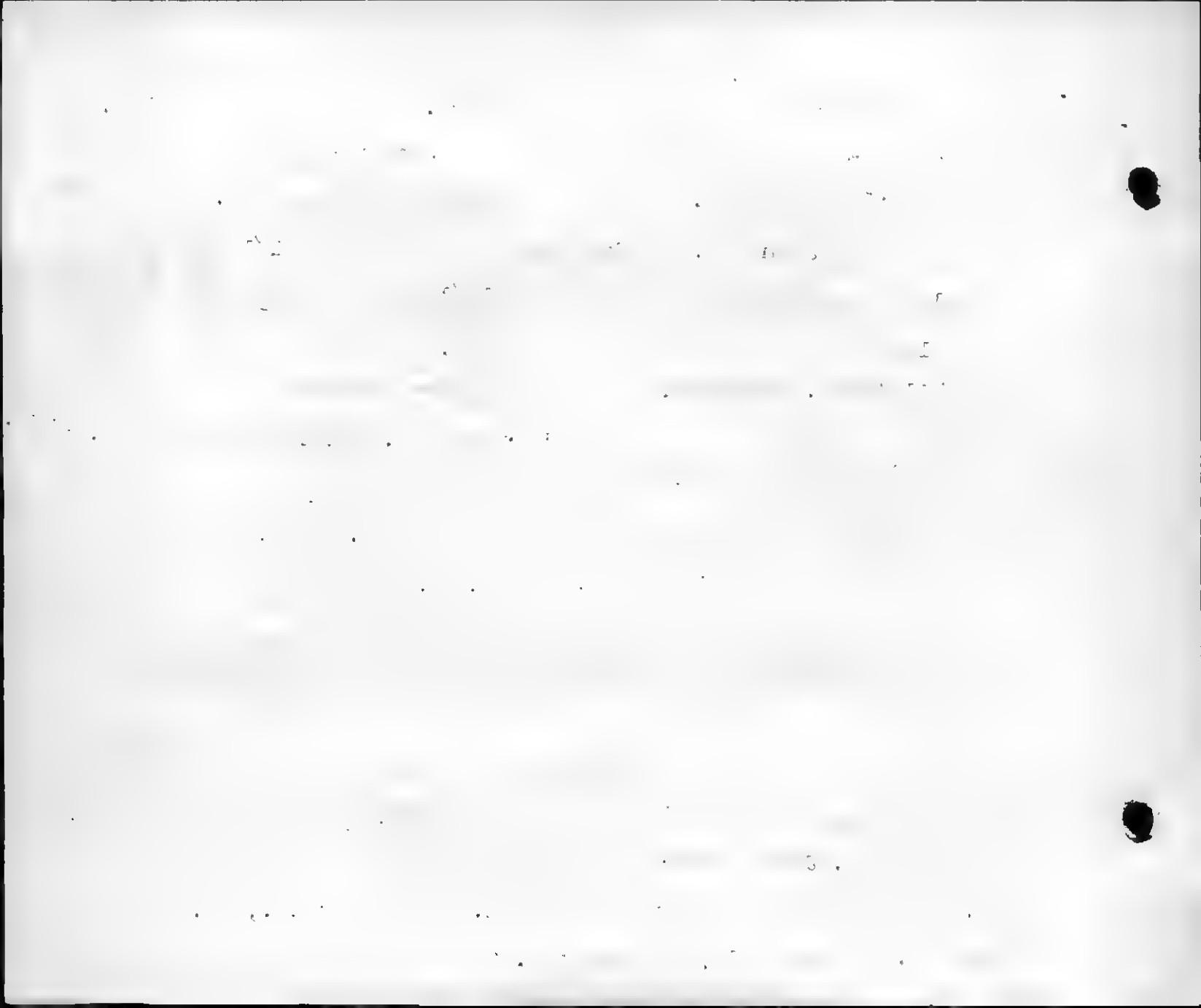
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0231 CERTIFICATE OF DEATH

Reg. Dist. No.

00361

1. PLACE OF DEATH a. COUNTY		Baltimore	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c LENGTH OF STAY IN lb		a. STATE	Md.
Halethorpe				b. COUNTY	Balto.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
1909 Halethorpe Ave.				57 Halethorpe	
3. NAME OF DECEASED (Type or print)		First John	Middle H.	Last Pinkerton	4. DATE OF DEATH 1/16/60
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 2/18/1894	Month 1 Day 16 Year 60
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (in years lost birthday) 65 yrs	IF UNDER 1 YEAR Months Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		B&O		Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
William K. Pinkerton		Louise Ehlers		USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		INFORMANT Address	
No				Henrietta A. Pinkerton 1909 Halethorpe Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Cerebrovascular Accident sec.</i> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. } (b) <i>8 Hypertension A.S.C.V.D.</i> DUE TO (c) <i>Old Coronary Occlusion</i>					
INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs.</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
19					
21. I certify that I attended the deceased from <i>1/3</i> , 1960, to <i>1/16</i> , 1960, that I last saw the deceased alive on <i>1/16</i> , 1960, and that death occurred at <i>7:28</i> P.M., from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) <i>Halethorpe, Md.</i> DATE SIGNED <i>1/18/60</i>					
ACTUAL SIGNATURE <i>John C. Healey M.D.</i>					
PHYSICIAN'S NAME (Type) Dr. John Healey					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/19/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Cedar Hill Cem.</i>	22d. LOCATION (City, town, or county) <i>Balto., Md.</i>	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Howard H. Hubbard</i>		ADDRESS <i>4107 Wilkens Ave. 29</i>	24a. REC'D BY REGISTRAR DATE JAN 19 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>	
VS A15 (4) TSM 9/58					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0373 CERTIFICATE OF DEATH

Reg. Dist. No.

00362

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pogie  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		Baltimore County Maryland		2. USUAL RESIDENCE (Where deceased lived - If institution, Residence before admission)				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STATE MARYLAND		b. COUNTY BALTIMORE		
LUTHERVILLE		2 yrs		X LUTHERVILLE, MD.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		1416 FRANCKE AVE		e. STREET ADDRESS		1416 FRANCKE AVE		
3. NAME OF DECEASED (Type or print)		First HORACE	Middle H.	Last PLATT	4. DATE OF DEATH	Month JANUARY	Day 10	Year 1960
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 5, 1909	9. AGE (In years last birthday) 50 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INDUSTRIAL ENGINEER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME HORACE H. PLATT		14. MOTHER'S MAIDEN NAME ISABEL JOHNSTON						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 1163-01-9928		INFORMANT MRS CHARLOTTE B. PLATT		Address 1416 FRANCKE AVE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cancer of lung		INTERVAL BETWEEN ONSET AND DEATH 2 mos		
163X		DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)
19 19								
21. I certify that I attended the deceased from alive on		1950, 19 to 1-10, 1960		and that death occurred at		9 AM		that I last saw the deceased
ACTUAL SIGNATURE								ADDRESS (Street, city or town, state)
PHYSICIAN'S NAME (Type)								DATE SIGNED
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF JAN 14, 1960		22c. NAME OF CEMETERY OR CREMATORIUM WEST LAUREL HILLS		22d. LOCATION (City, town, or county) PHILADELPHIA, PENNSYLVANIA		(State)
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS 4905 YORK RD., BALTIMORE, MD.		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
HENRY W. JENKINS & Sons Co.						Arthur S. Thomas		
				DATE JAN 12 '60				



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0378 CERTIFICATE OF DEATH

Reg. Dist. No.

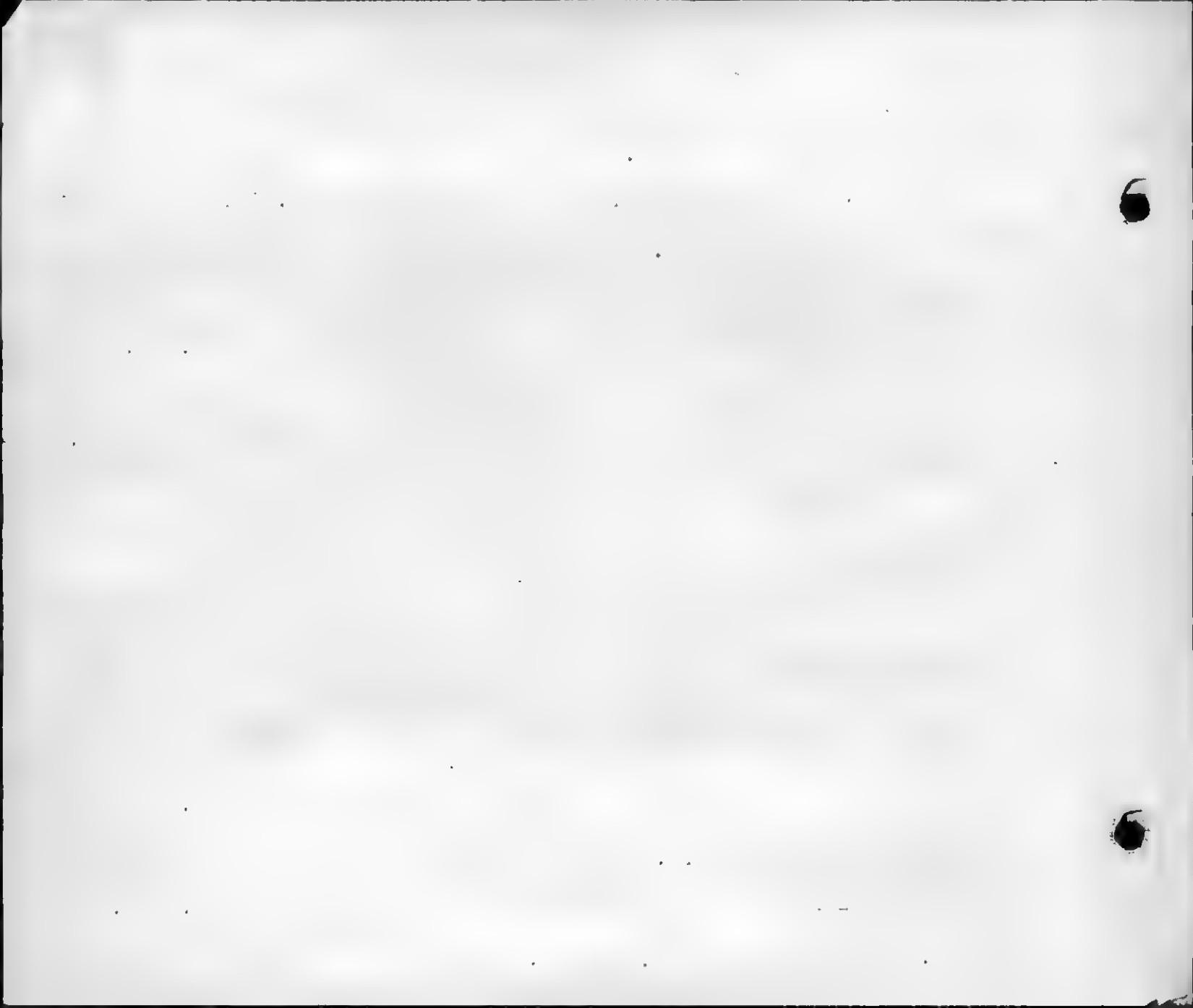
00363

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>3 Mo.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8301 Old Harford Rd.</b>				d. STREET ADDRESS <b>2900 Wells Ave. 19,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNA</b>		First <b>M.</b>	Middle <b></b>	Last <b>OGNETTI</b>	4. DATE OF DEATH <b>JANUARY 29 1960</b>	Month <b>JANUARY</b>	Day <b>29</b>	Year <b>1960</b>	
S SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>July 23, 1886</b>	9. AGE (In years from birthday) <b>73</b> yrs.	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS Days <b></b>	12. IF UNDER 24 HRS Hours <b></b>	13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Zazach</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Dorothy Golliday 8301 Old Harford Rd.</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO <b>PULMONARY HEMORRAGE</b>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) DUE TO <b>METASTATIC CARCINOMA OF LUNG</b>							
(c) DUE TO <b>PRIMARY CARCINOMA OF STOMACH</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		CONGESTIVE HEART FAILURE				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Philadelphia Pd</b>		(County) <b>Philadelphia</b>	(State) <b>Pd</b>
21. I certify that I attended the deceased from <b>1-25</b> , 19 <b>60</b> , to <b>1-29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-29</b> , 19 <b>60</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>8619 Philadelphia Pd</b>		DATE SIGNED <b>1-29-60</b>	
ACTUAL SIGNATURE <i>John G. Orth, M.D.</i>									
PHYSICIAN'S NAME (Type) <b>John G. Orth, M.D.</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-1-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Sacred Heart of Jesus</b>		22d. LOCATION (City, town, or county) <b>German Hill Rd. Md.</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. 22, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 1 '60</b>		24b. REGISTRAR'S SIGNATURE <i>John S. Kraus</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0379

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

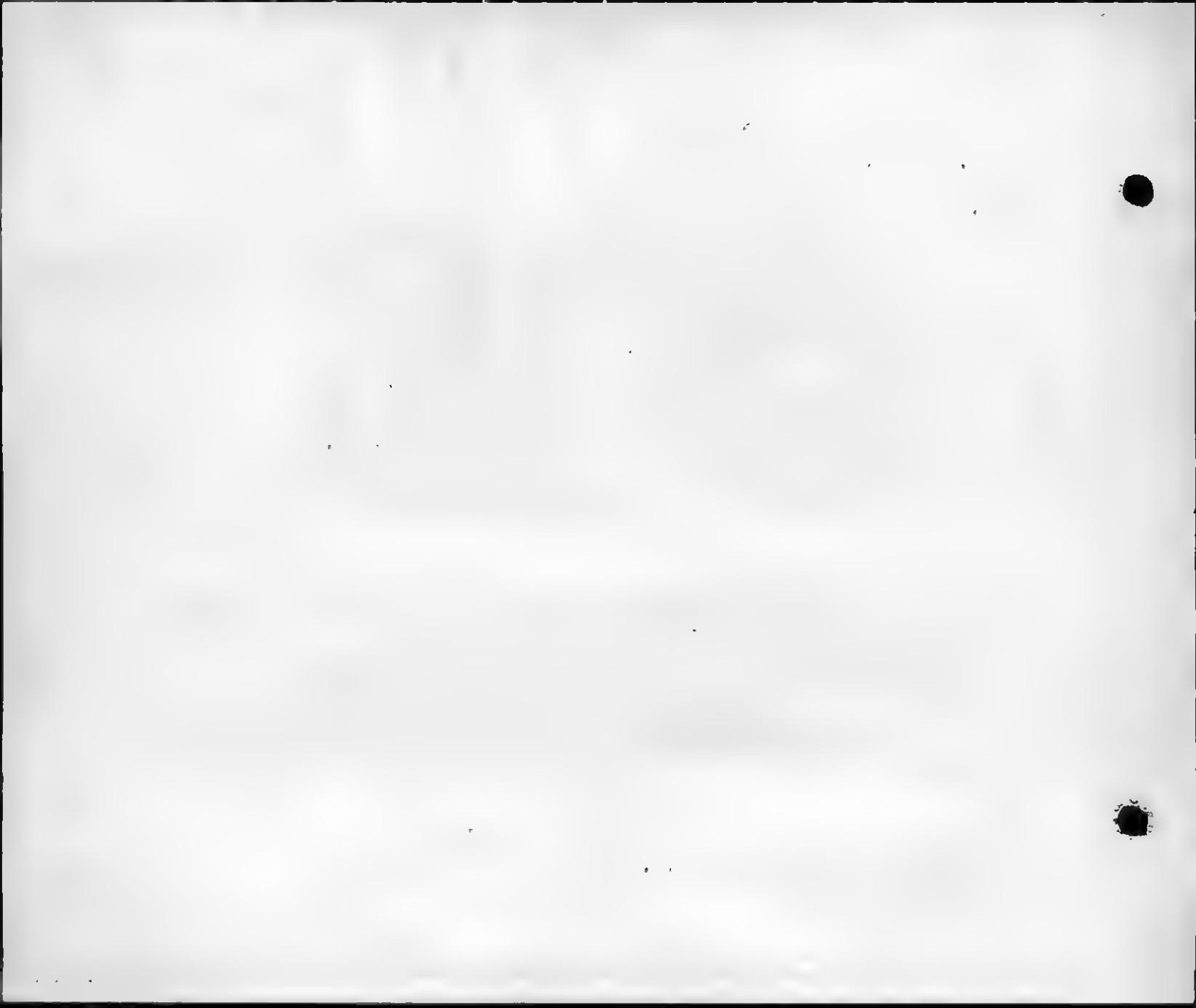
11/364

1 X M		2	
1 PLACE OF DEATH a. COUNTY Baltimore County		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Wilson, Maryland		b. COUNTY Balt. City ✓	
c. LENGTH OF STAY IN lb 113 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 11	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt. Wilson State Hospital		d. STREET ADDRESS 4322 Evans Chapel Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First Carroll	Middle Younger
		Last Pomeroy	4. DATE OF DEATH Jan 22 1960
5. SEX male		6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
		8. DATE OF BIRTH Feb. 9, 1899	
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Railway Express	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY U. S. A.			
13. FATHER'S NAME James H. Pomeroy		14 MOTHER'S MAIDEN NAME Mary O'Connor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 214-24-8939	17. INFORMANT Address Hospital Records, Mt. Wilson State Hospital
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Pulmonary Tuberculosis	
002X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO INTERVAL BETWEEN ONSET AND DEATH 3 Years	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Aplastic Anemia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 2 1959, to Jan 22 1960, that I last saw the deceased alive on Jan 22, 1960, and that death occurred at 7:15 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE L. J. L. 11/26/60		M.D. Mt. Wilson, Maryland	
PHYSICIAN'S NAME (Type) William Newcomer, M.D.		Superintendent	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/26/60	22c. NAME OF CEMETERY OR CREMATORIUM Bridg Ridge
22d. LOCATION (City, town, or county) Elkville Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE A. Donovan - 3818 Bladefield		24a. REC'D BY REGISTRAR Date JAN 27 '60	24b. REGISTRAR'S SIGNATURE C. L. & T. Inc.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 File #254 1-2-50 et

0380

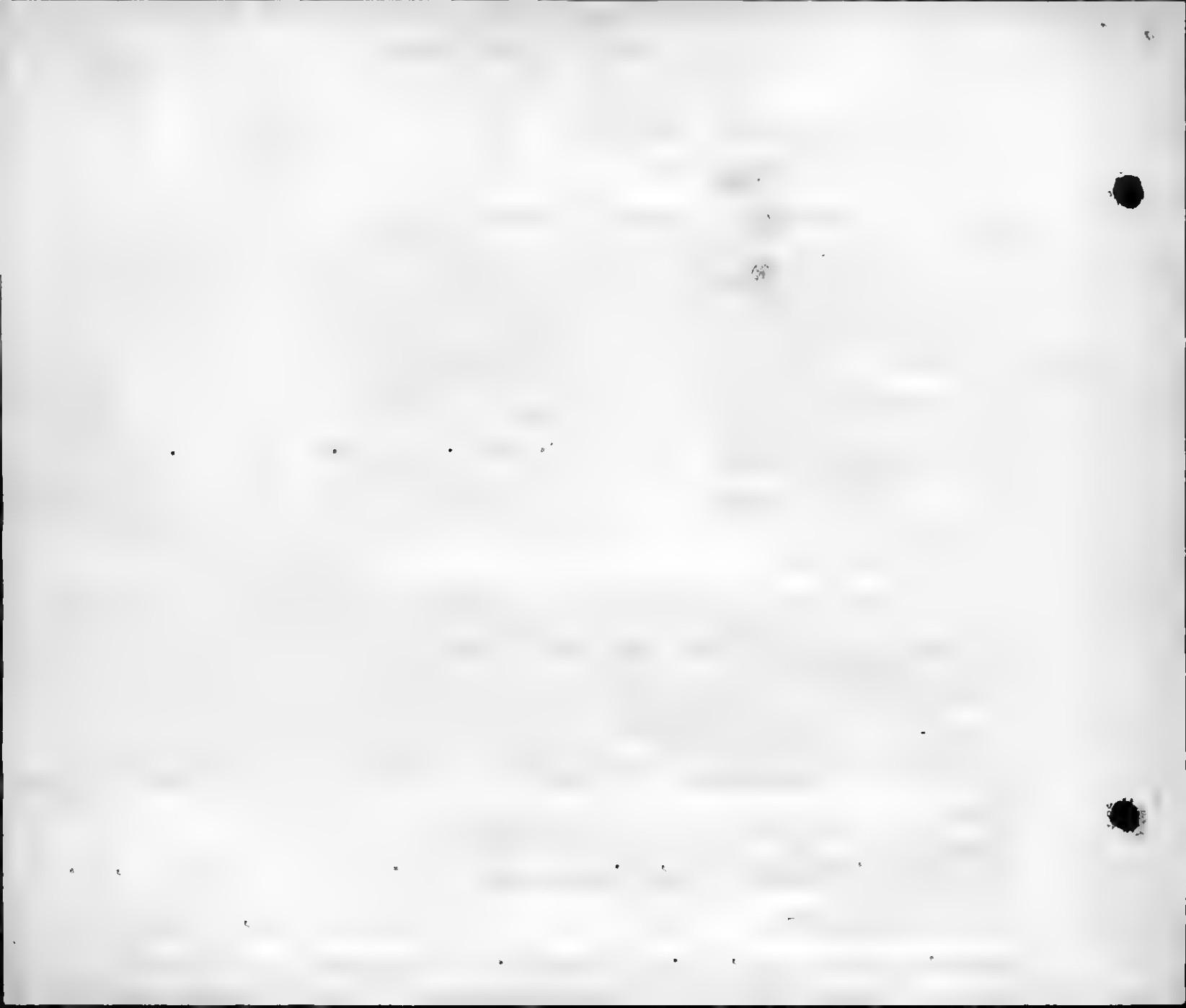
## CERTIFICATE OF DEATH

Reg. Dist. No.

00365

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in it may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** If this certificate is detached for use as the burial-transit permit, then please remove carbon copies. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shady Nook Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 Catonsville	
3. NAME OF DECEASED (Type or print) Irene Nicewander Poor		d. STREET ADDRESS 16 Wymcrest Avenue	
4. DATE OF DEATH January 13	Month 19	Day 60	Year
5. SEX White	6. COLOR OR RACE Female	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 13, 1874
9. AGE (in years last birthday) 85 6 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ephriam Nicewander		14. MOTHER'S MAIDEN NAME Margaret Ann Newcomer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT Address Jr. John B. Rown 2 E. Lexington St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> Arteriosclerotic cardiovascular Disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH 10 yrs			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> Bronchopneumonia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-13-50, 19, to 1-13-60, 19, that I last saw the deceased alive on 1-13-60, 19, and that death occurred at 8:49 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE John A. Nesbitt Jr. M.D. DATE SIGNED 1-14-60 PHYSICIAN'S NAME (Type) Dr. John A. Nesbitt, Jr. 1118 St. Paul Street Baltimore, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-15-60	
22c. NAME OF CEMETERY OR CREMATORIAL Green Mount		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John O. Mitchell & Sons, Inc. 1900 Eutaw Pl.		ADDRESS	
		24a. REC'D BY REGISTRAR DATE JAN 15 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



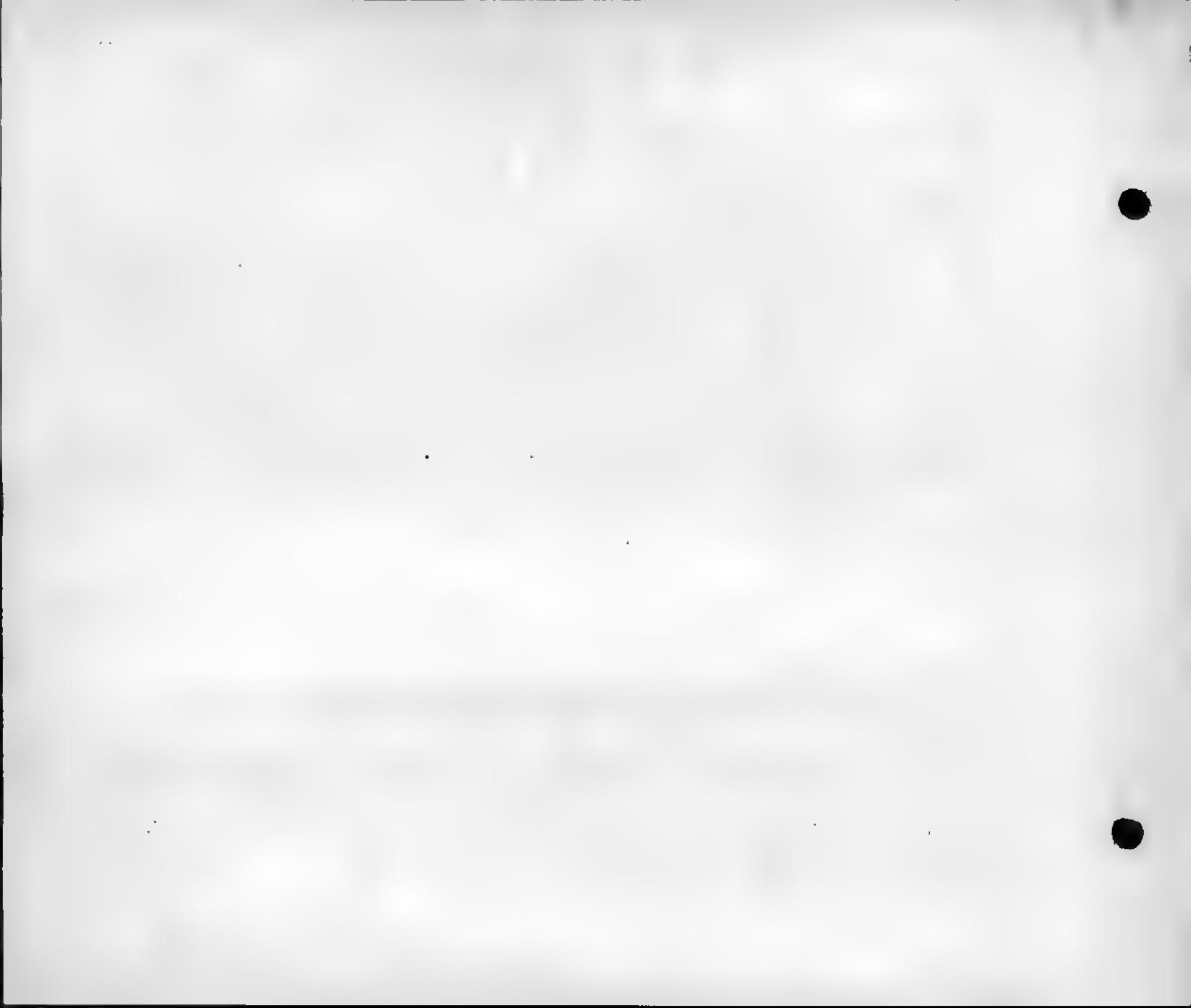
**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be detached from the original certificate and used as the burial transit permit. Then please remove section pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**0381 CERTIFICATE OF DEATH**

Reg. Dist. No. 00366

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ruxton X						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1516 Berwick Avenue	d. STREET ADDRESS 1516 Berwick Avenue #4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) CHARLES ELLSWORTH POTTS	First	Middle	Last	4. DATE OF DEATH Jan. 18 19 60	Month	Day	Year	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 20, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Pennsylvania Railroad		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME John Potts			14. MOTHER'S MAIDEN NAME -----					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Elsie T. Potts-1516 Berwick Avenue		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Atherosclerosis (c)						INTERVAL BETWEEN ONSET AND DEATH 2 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 6805 York Rd		(County) (State) Baltimore Md
21. I certify that I attended the deceased from _____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____ P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Laurence C. Post Laurence C. Post Baltimore 12 Md						
ACTUAL SIGNATURE Laurence C. Post	PHYSICIAN'S NAME (Type) Laurence C. Post	DATE SIGNED 1/19/60						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/21/60	22c. NAME OF CEMETERY OR CREMATORIUM Baltimore Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Ticknor & Sons		ADDRESS Baltimore 17 Md.	24a. REC'D BY REGISTRAR 20 60		24b. REGISTRAR'S SIGNATURE Laurence C. Post			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

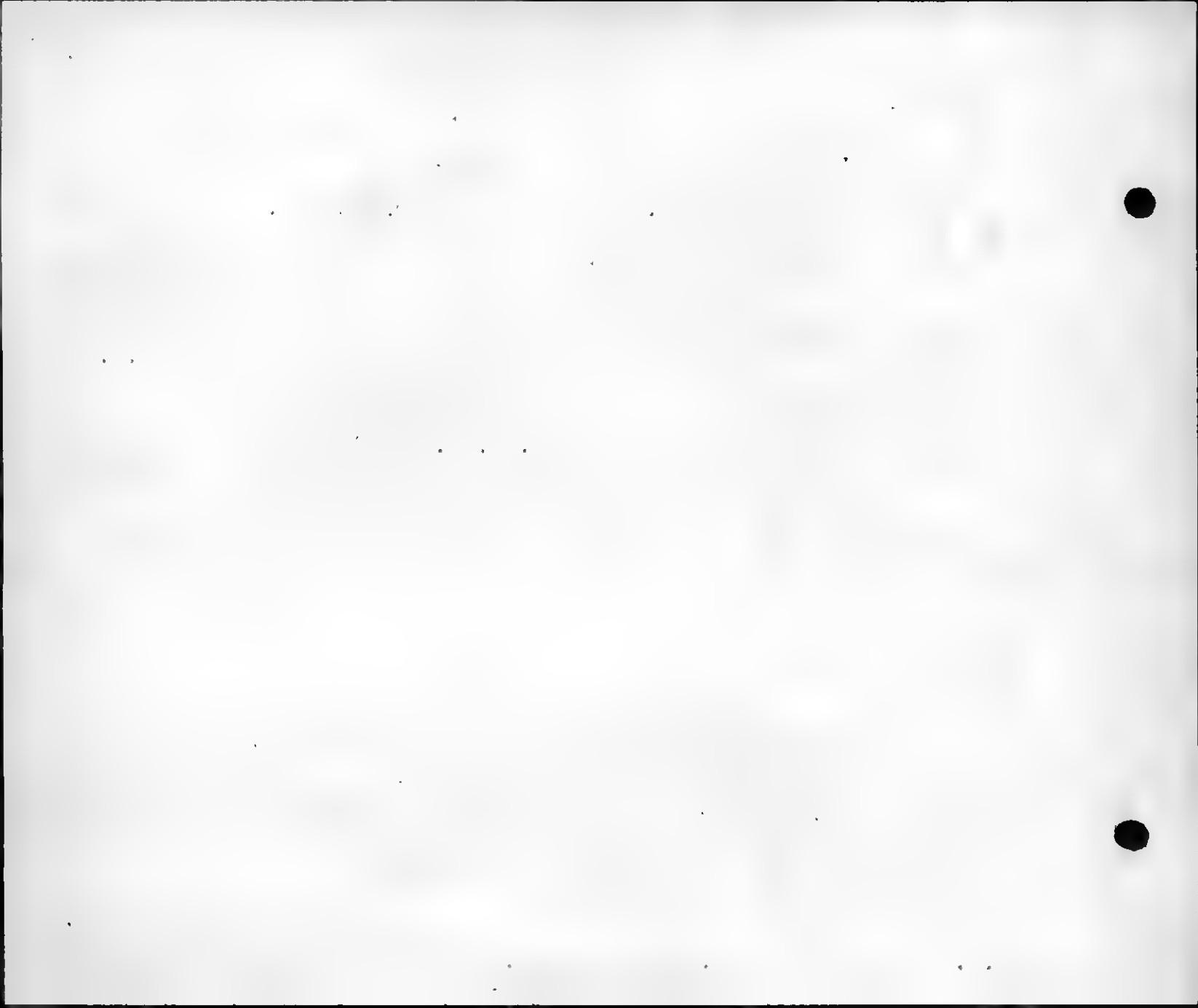
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0382 CERTIFICATE OF DEATH

Reg. Dist. No.

00367

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b <b>RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Towson Conv. Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mamie</b>		First <b>M.</b>	Middle <b>M.</b>
Last <b>Potts</b>		4. DATE OF DEATH <b>Jan. 26</b>	Month <b>Jan.</b>
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>April 5, 1886</b>		9. AGE (In years 1st birthday) <b>73 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Houserwife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b></b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
13. FATHER'S NAME <b>Louis Krause</b>		14. MOTHER'S MAIDEN NAME <b>Wilhelmena Simon</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b></b>	INFORMANT <b>Mrs. G. R. Schmidt</b>
		Address <b>Above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocarditis</b>			
550X		DUE TO <b>Parkinsons Disease</b>	INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs.</b>
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>
20f. (City or town) <b></b>		(County) (State) <b></b>	
21. I certify that I attended the deceased from <b>Dec 12, 1959</b> , to <b>Jan 26, 1960</b> , that I last saw the deceased alive on <b>Jan. 26, 1960</b> , and that death occurred at <b>11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Carl J. Benson M.D.</b>		ADDRESS (Street, city or town, state) <b>5111 York St.</b>	
PHYSICIAN'S NAME (Type) <b></b>		DATE SIGNED <b></b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-29-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Parkwood</b>
22d. LOCATION (City, town, or county) <b>Parkville</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H.W. Jenkins &amp; Sons Co.</b>		24a. REC'D. BY REGISTRAR DATE <b>JAN 27 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Ciribus S. Hanna</b>
ADDRESS <b>4905 York Rd.</b>			
Balto. MD.			



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE  
HEALTH DEPT.

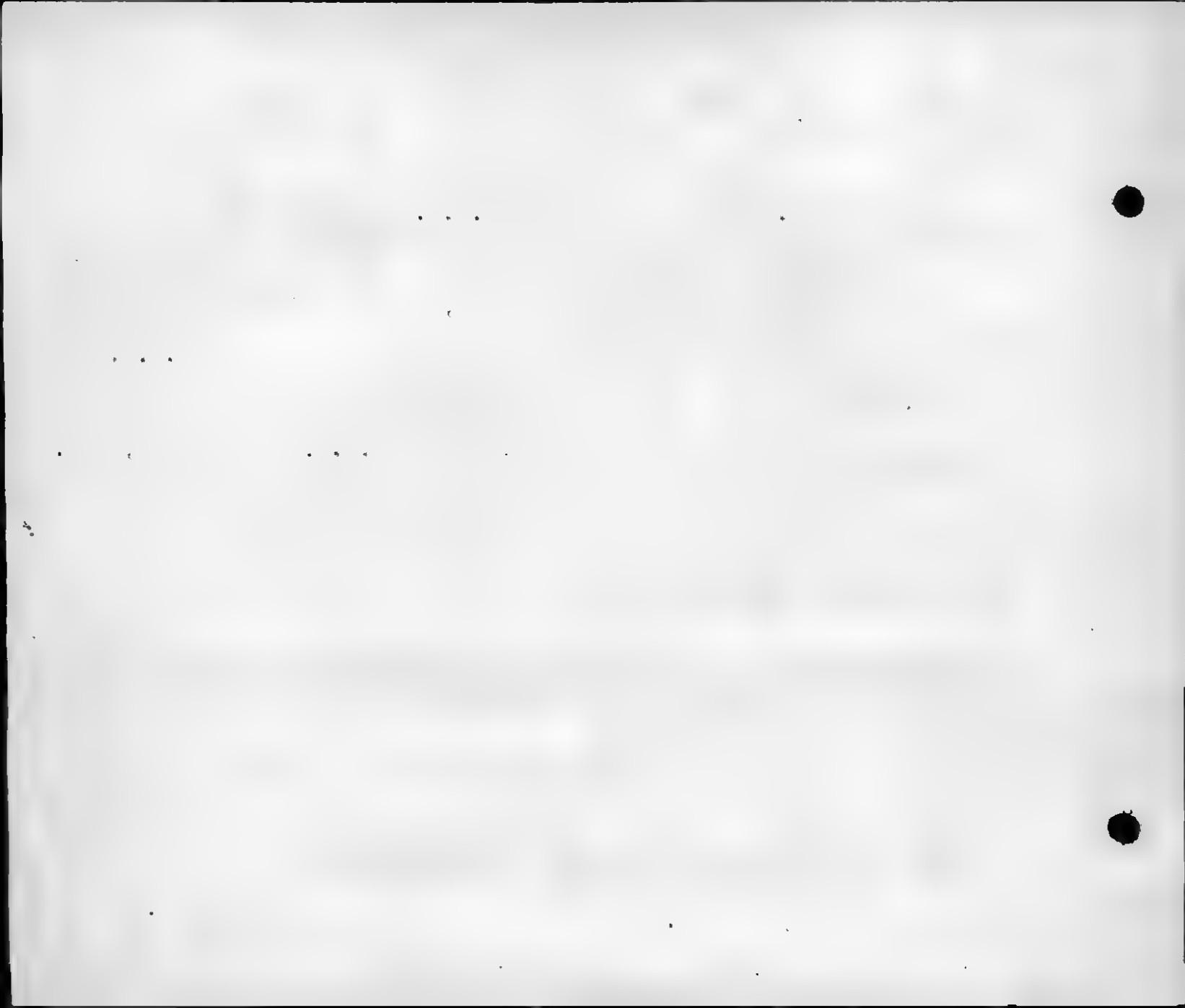
Reg. Dist. No.

00368

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained by your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		0232 MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE <b>Pennsylvania</b> <sup>b</sup> COUNTY <b>Schuylkill</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lansdowne</b>		c. LENGTH OF STAY IN lb <b>1 Month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pine Grove</b>		d. STREET ADDRESS <b>R.F.D. 1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>326 Third Ave.</b>						e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Elsie Luella Powell</b>		First	Middle	Lost	4. DATE OF DEATH <b>January 9</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 27, 1890</b>	9. AGE (In years last birthday) <b>69</b>	yr	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John K. Kieffer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Porter</b>				Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>James Powell R.F.D. 1 Pine Grove, Penn.</b>		INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) gave rise to underlying cause (c), stating the underlying cause last.									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Geo. S. M. Kieffer</i>		DATE SIGNED <i>1-9-60</i>							
EXAMINER'S NAME (Type) <b>GEO. S. M. KIEFFER</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/12/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Johns Cemetery</b>		22d. LOCATION (City, town, or county) <b>Pine Grove, Penna.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Emilie, Inc. 1328 Sulphur St. Rd.</i>		ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

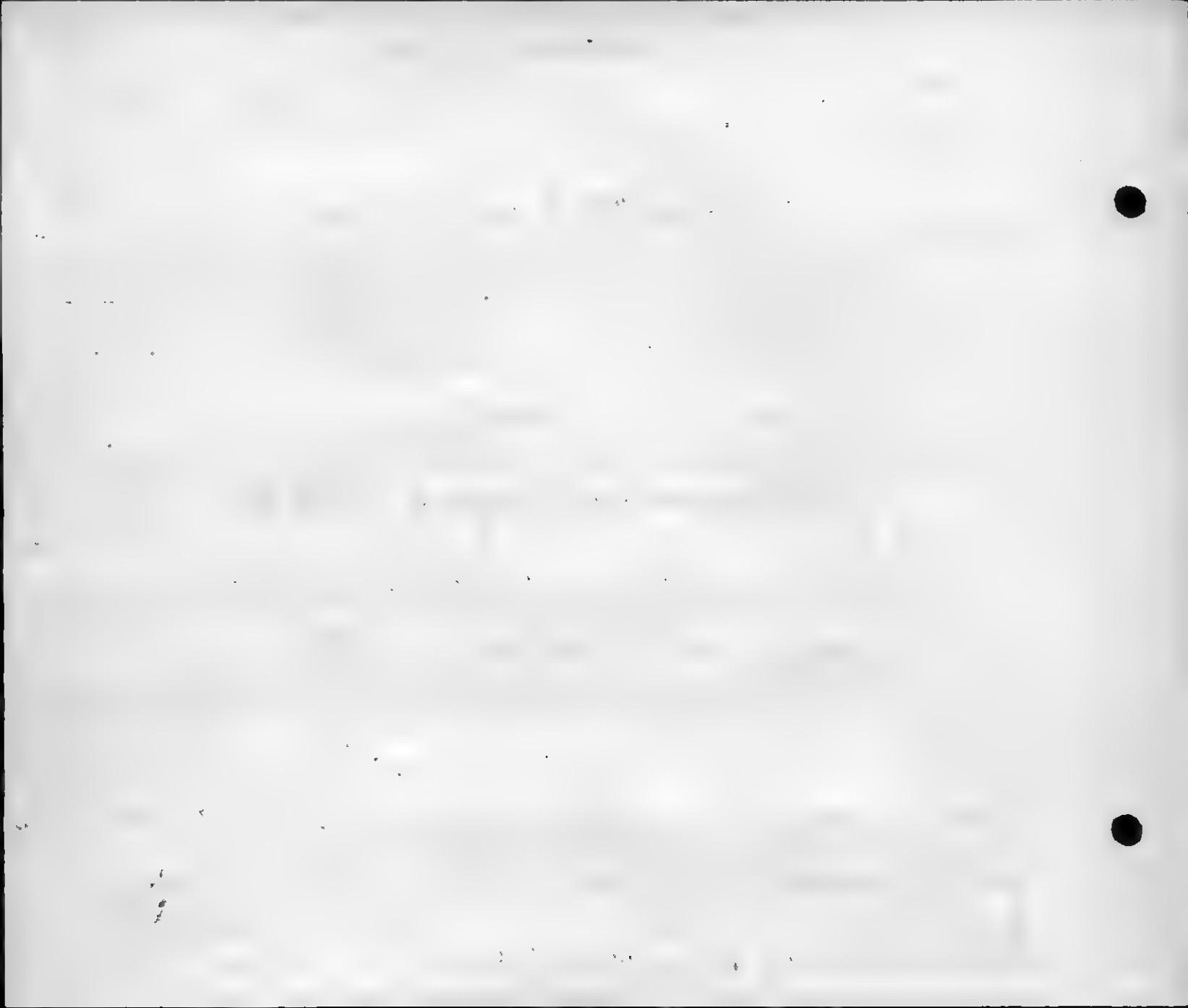
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00360

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29,	c. LENGTH OF STAY IN 1b 8 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 29,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1008 Beechfield Ave.		d. STREET ADDRESS 1008 Beechfield Ave 29 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anthony	First Middle Last Anthony Puceta	4. DATE OF DEATH January 24 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1877
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	11. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor - Retired		10b. KIND OF BUSINESS OR INDUSTRY Coat - Maker	11. BIRTHPLACE (State or foreign country) Lithuania
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212/18/5176	17. INFORMANT Mary Puceta Address 1008 Beechfield Ave.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 days 14 days 10 yrs.	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p.m.	Month Day Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____ 1-11, 1949, to _____ 1-24, 1960, that I last saw the deceased alive on _____ 1-22, 1960, and that death occurred at _____ 9:50 AM, from the causes and on the date stated above		ADDRESS (Street, city or town, state) John P. Ulwick Jr. M.D. 1227 Waver Blvd Bel Air 30461 1/26/60	
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 28, 1960	22c. NAME OF CEMETERY OR CREMATORIAL Most Holy Redeemer
22d. LOCATION (City, town, or county) Bel Air Rd. Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Thos. W. Kaehnkeas 637 Wash Blvd.		24a. REC'D BY REGISTRAR DATE JAN 28 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus
		30 min.	



1  
FOR STATE  
HEALTH DEPT.



TO FUNERAL DIRECTOR: This certificate should be executed within 24 hours after death. If any detail necessary, please execute a certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00370  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

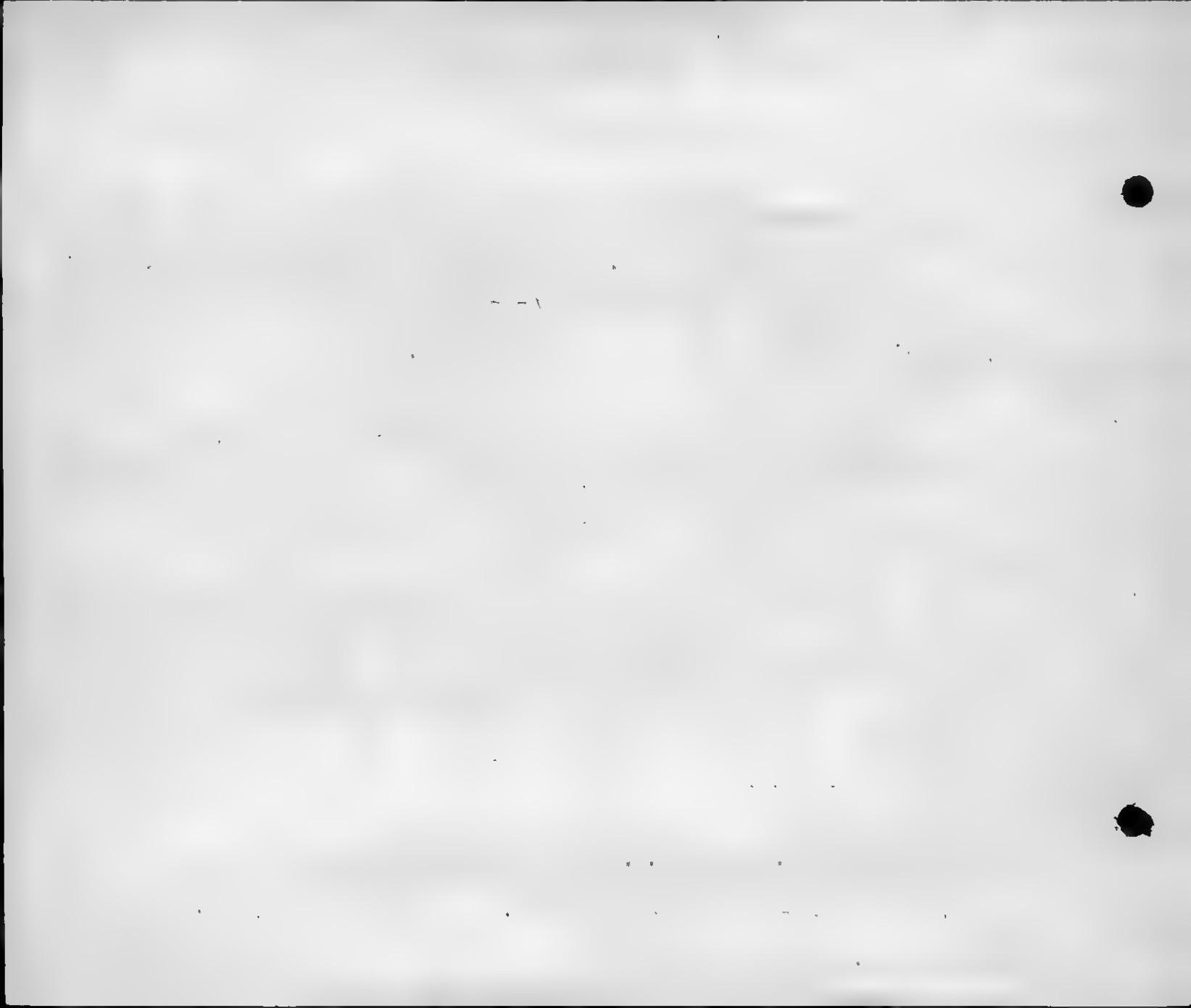
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>	0384 Item 14 11-54 1-16-60 et	2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Maryland</b>	b. COUNTY <b>Baltimore</b>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	d. STREET ADDRESS <b>2808 Hillcrest Road</b>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>2808 Hillcrest Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RUTH</b>	First <b>L.</b>	Middle <b>PUND</b>	Last <b>January 10, 1960</b>
4. DATE OF DEATH <b>1-3-1893</b>	Month <b>January</b>	Day <b>10</b>	Year <b>1960</b>
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b>	8. DATE OF BIRTH <b>1-3-1893</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Penna.</b>	9. AGE (In years last birthday) <b>67 yrs.</b>
13. FATHER'S NAME <b>Redeker</b>	14. MOTHER'S MAIDEN NAME <b>Unknown</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or date of service) <b>No</b>
16. SOCIAL SECURITY NO.	17. INFORMANT <b>Mrs Ethel Booth</b>	Address <b>sane</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **Recent myocardial infarct**  
**420.1**  
DUE TO **coronary sclerosis**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).  
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED?  
YES  NO

20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>1/11/60</b>	
ACTUAL SIGNATURE <b>Russell S Fisher</b>	EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>	Address (Street, city, town, or county)	22d. LOCATION (City, town, or country)	(State)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1-13-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Moreland Mem.</b>	Baltimore, Md.		
23. FUNERAL DIRECTOR <b>Leonard J. Ruck 5305 Harford Rd</b>	ADDRESS <b>Leonard J. Ruck 5305 Harford Rd</b>	24a. REC'D BY REGISTRAR <b>JAN 13 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

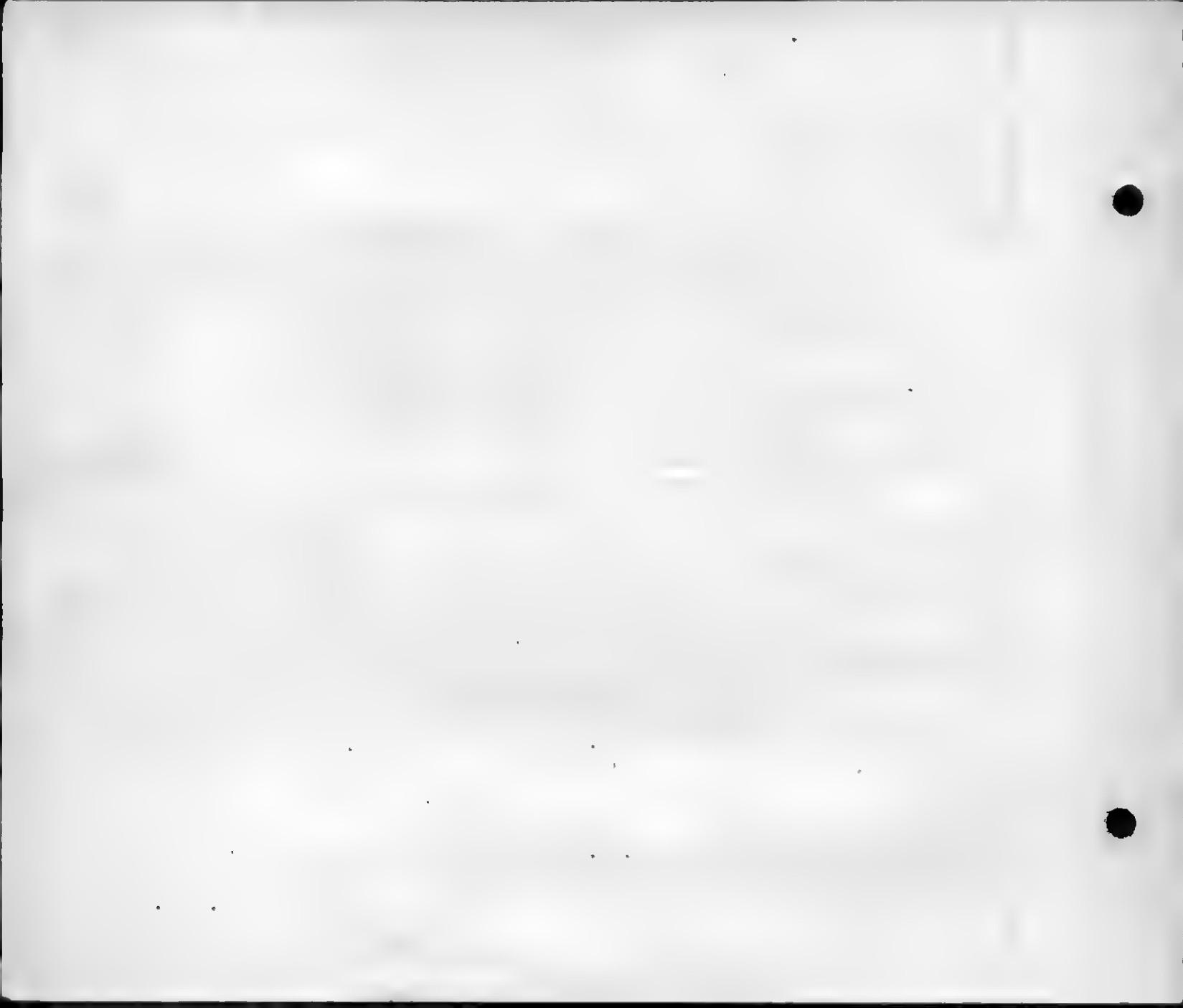
00371

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE				
Baltimore MARYLAND		Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN 1b	b. COUNTY				
Catonsville	1yr 6nth lldys					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS					
SPRING GROVE STATE HOSPITAL	2006 Gough Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First	Middle	Last			
	Bertha		Raczkowski			
4. DATE OF DEATH	Month	Day	Year			
	January	8	19 60			
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS
Female	white	WIDOWED <input checked="" type="checkbox"/>	February 15, 1896	63 yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
housewife				Poland		Poland
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME		
Joseph Kocon				Mary Zatorski		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
Unknown		Unknwon		Records: SPRING GROVE STATE HOSPITAL		
Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure INTERVAL BETWEEN ONSET AND DEATH						
422.1 DUE TO						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pneumonia						
DUE TO (c) Arteriosclerotic cardiovascular disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
Diabetes mellitus 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
Dec. 1 1959 19						
21. I certify that I attended the deceased from Dec. 1, 1959, to Jan. 8, 1960, that I last saw the deceased alive on Jan. 8, 1960, and that death occurred at 1:05a. M., from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Stella Wachsler</i> ADDRESS (Street, city or town, state) DATE SIGNED M.D. SPRING GROVE STATE HOSPITAL 1-8-60						
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D. Catonsville 28, Maryland						
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
Burial		1/11/1960		Holy Rosary Cemetery		Baltimore Co. Md.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
<i>John D. Webster Sons Inc. 4018 Chester St.</i>				DATE JAN 11 '60		<i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, one funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

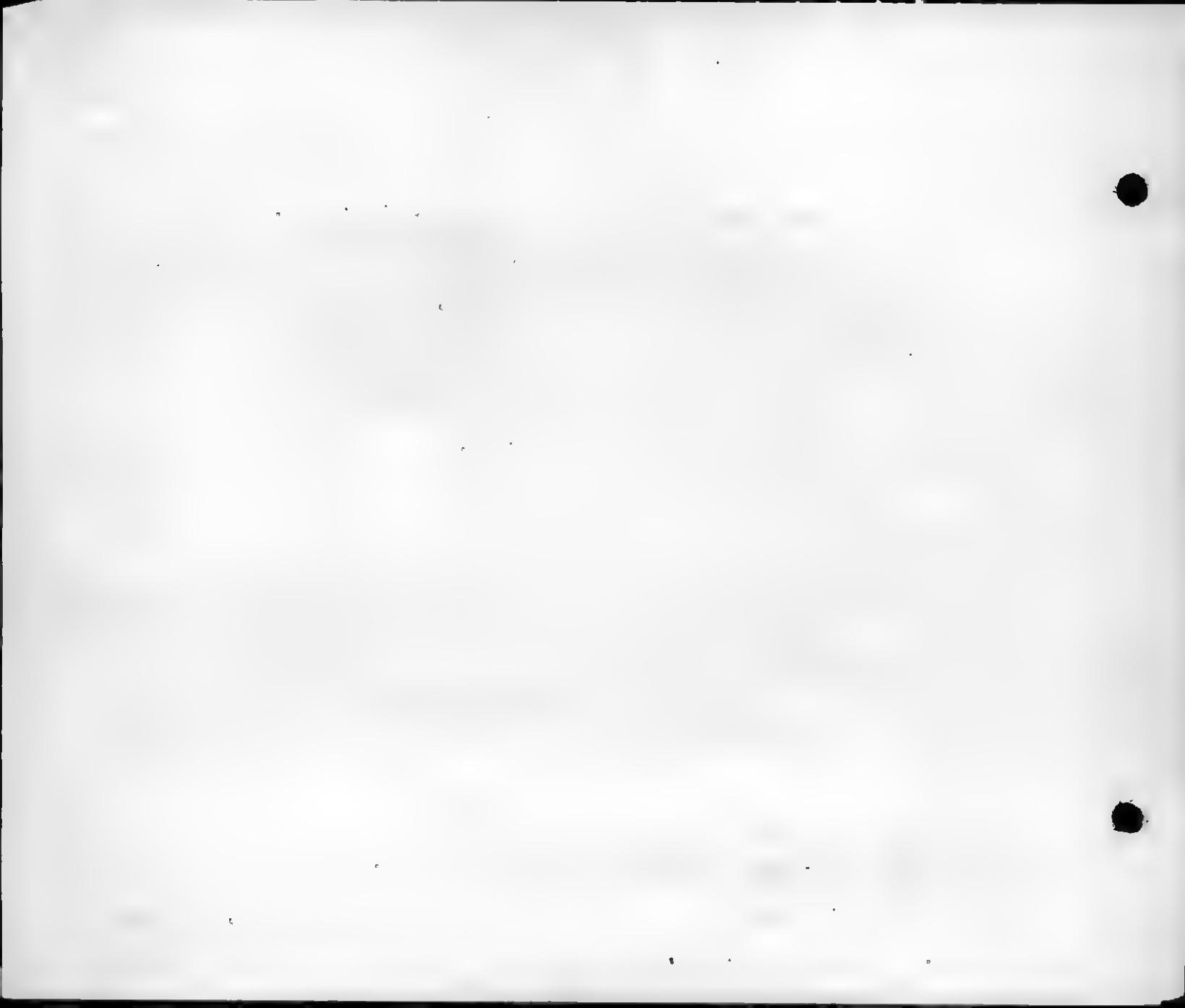
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND**

**CERTIFICATE OF DEATH**

0385 00372

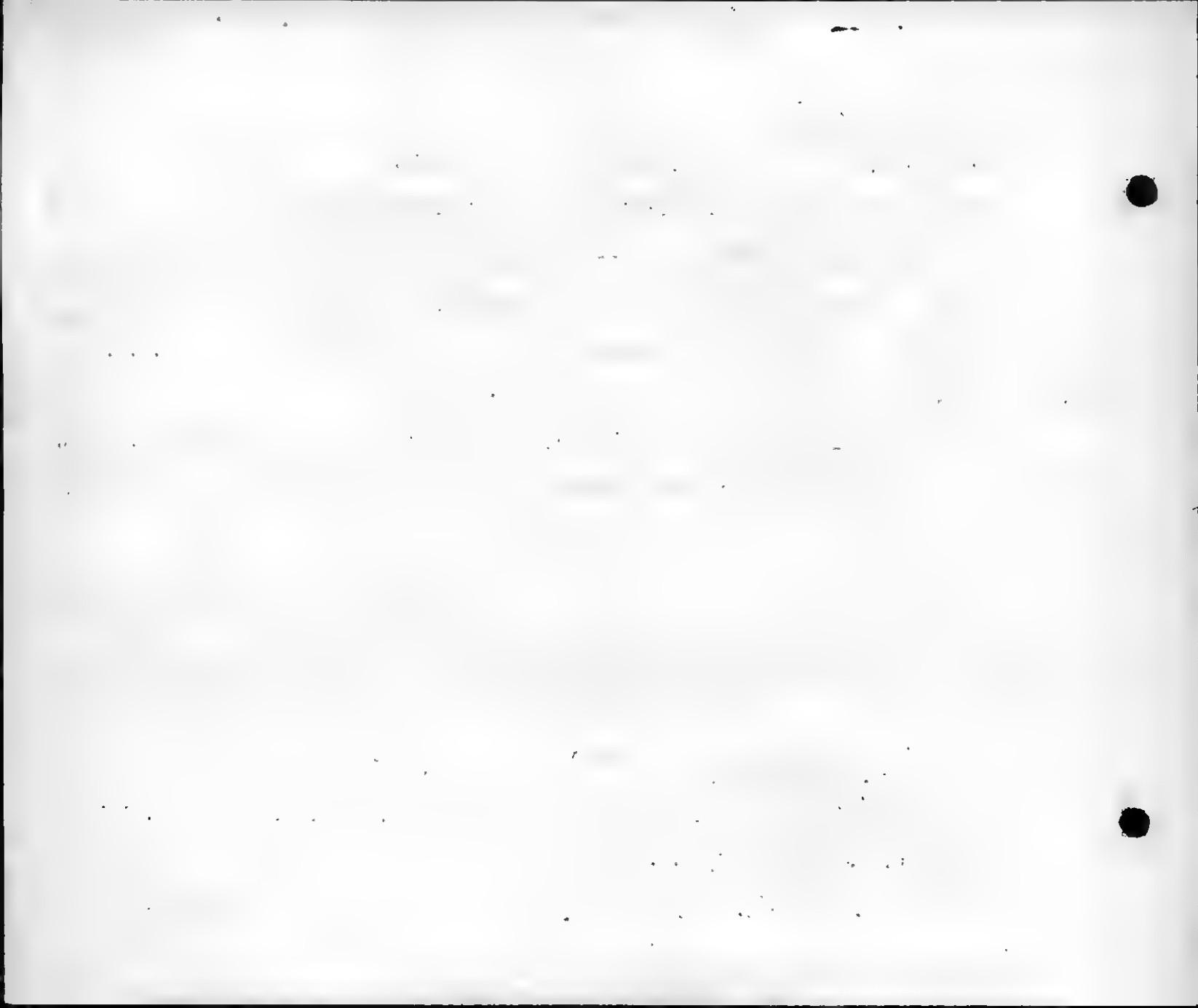
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>3333 N. Charles St.</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Armacost Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Cornelia Gibson</b>		First	Middle	Last	4. DATE OF DEATH <b>January 23, 1960</b>	Month	Day	Year		
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1875</b>	9. AGE (In years last birthday) <b>84 yrs</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Restaurant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME <b>John Gibson</b>				14. MOTHER'S MAIDEN NAME <b>Cornelia Weems</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Robert B. Rector 701 Thplow Lpad</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) DUE TO  Arteriosclerosis DUE TO  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Rheumatoid Arthritis										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>10/12, 1955, la</b>		(County) (State) <b>1423, 1960</b>		
21. I certify that (I) (this hospital) attended the deceased from _____ saw the deceased alive on _____		10/12, 1955, la		1423, 1960		that (I) (we) last and that death occurred at <b>2<sup>nd</sup> AM</b> , from the causes and on the date stated above.				
22a. SIGNATURE <b>J. Frank Supplee</b>		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>1/23/60</b>						
22c. PHYSICIAN'S NAME (Type) <b>Dr. J. Frank Supplee</b>		22d. ADDRESS <b>1014 St. Paul Street</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1/25/60</b>		23c. NAME OF CEMETERY OR CREMATORIAL <b>Druid Ridge</b>		23d. LOCATION (City, town, or county) <b>Pikesville, Maryland</b>			(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons, Inc.</b>		ADDRESS <b>1900 Eutaw Place</b>		25a. REC'D BY REGISTRAR <b>JAN 25 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			DATE	
TYPE OR PRINT <b>VR ATS (4) TSM 1/59</b>										



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**OR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										Reg. Dist. No. 00373				
0387 CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>					c. LENGTH OF STAY IN lb <b>5 DAYS</b>					d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>					e. STREET ADDRESS <b>1136 E MADISON STREET</b>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>JAMES</b>		Middle —		Last <b>REDICK</b>		4. DATE OF DEATH Month <b>JANUARY</b>		Day <b>26</b>		Year <b>1960</b>		
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>COLORED</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>JANUARY 30 1894</b>		9. AGE (In years last birthday) <b>65 yrs.</b>		10. IF UNDER 1 YEAR Months <b>12</b>		11. IF UNDER 24 HRS. Days <b>CITIZEN OF WHAT COUNTRY?</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DYE FACTORY</b>		11. BIRTHPLACE (State or foreign country) <b>NORFOLK VIRGINIA</b>		12. U.S.A.								
13. FATHER'S NAME <b>ALBERT REDICK</b>					14. MOTHER'S MAIDEN NAME <b>HATTIE CROSS</b>					Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no or unknown, (If yes, give war or dates of service) <b>YES WW-1</b>					16. SOCIAL SECURITY NO. <b>218-10-3061</b>					INTERMEDIATE <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>										INTERVAL BETWEEN ONSET AND DEATH <b>2 WEEKS</b>				
491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO														
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		Month 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VAH, BALTO. 18, MD. FT. HOWARD BIV.</b>		(County) <b>1/27/60</b>		(State)		
21. I certify that I attended the deceased from <b>January 21, 1960</b> , to <b>January 26, 1960</b> and that death occurred at <b>7:00 PM</b> , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) <b>M.D.</b> VAH, BALTO. 18, MD. FT. HOWARD BIV. 1/27/60				
ACTUAL SIGNATURE 										DATE SIGNED <b>1/27/60</b>				
PHYSICIAN'S NAME (Type) <b>W. J. PIJANOWSKI, M.D.</b>														
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1/29/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>BALTIMORE NATIONAL</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>		(State)						
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S Phillips</b>					1808 N Monroe St. Baltimore 17, Md.		24a. REC'D BY REGISTRAR <b>FEB 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. Hunt S. Krause</b>					
VS A1S (4) 15M 9/58														

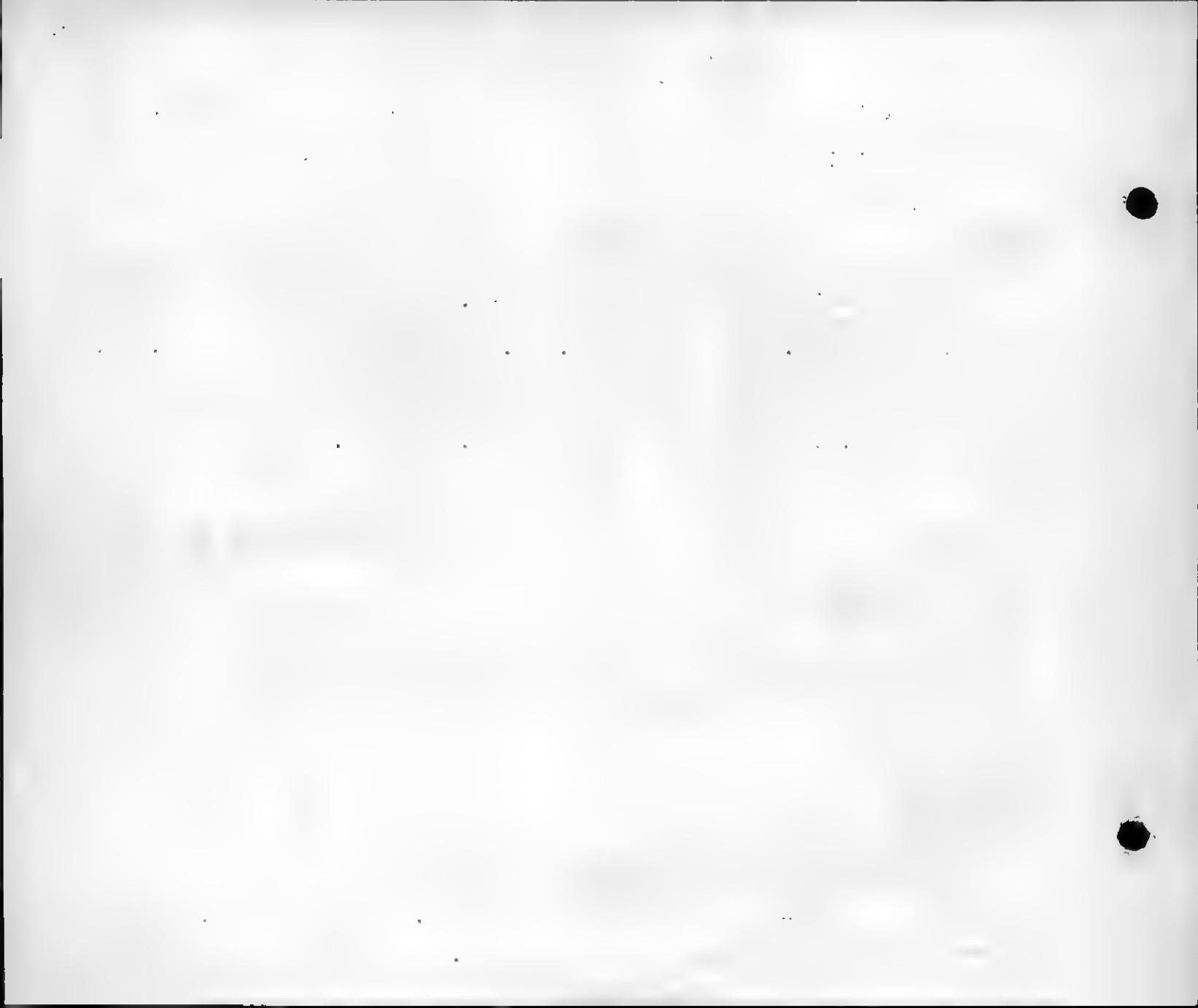


## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 10374

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN 1b <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Road</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>	
3. NAME OF DECEASED (Type or print) <b>George</b>		First <b>Anton</b>	Middle <b>Reier</b>
4. DATE OF DEATH <b>January 16, 1960</b>		Month <b>January</b>	Day <b>16</b>
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <b>WIDOWED</b>
8. DATE OF BIRTH <b>Feb. 21, 1894</b>		9. AGE (In years last birthday) <b>65</b>	10. IF UNDER 1 YEAR Months <b>65</b>
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. IF UNDER 24 HRS Hours <b>65</b>	13. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
14. FATHER'S NAME <b>Anton Reier</b>		15. MOTHER'S MAIDEN NAME <b>Wilhelmenia Weinrich</b>	
16. SOCIAL SECURITY NO. <b>W.W. I 212-05-7374</b>		17. INFORMANT <b>Mrs. Helen B. Reier</b>	
18. MEDICAL CERTIFICATION		19. ADDRESS <b>York Road Cockeysville</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m.      19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1946</b> , to <b>16 Jan 1960</b> , that I last saw the deceased alive on <b>16 Jan 1960</b> , and that death occurred at <b>6 P.M.</b> from the causes and on the date stated above.		22. ADDRESS (Street, city or town, state) <b>M.D. 6701 York Rd Baltimore 12 Maryland</b>	
23. ACTUAL SIGNATURE <b>Charles H. Reier</b>		DATE SIGNED <b>18 Jan 1960</b>	
24a. PHYSICIAN'S NAME (Type) <b>Charles H. Reier</b>		24b. REGISTRAR'S SIGNATURE <b>Charles J. Grace</b>	
24c. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24d. DATE THEREOF <b>1-19-60</b>	
24e. NAME OF CEMETERY OR CREMATORIUM <b>Dulaney Valley MEM.</b>		24f. LOCATION (City, town, or county) <b>Timonium, Md.</b>	
24g. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service</b>		24h. ADDRESS <b>Towson 4, Md.</b>	
24i. REC'D BY REGISTRAR <b>JAN 19 1960</b>		24j. DATE <b>JAN 19 1960</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

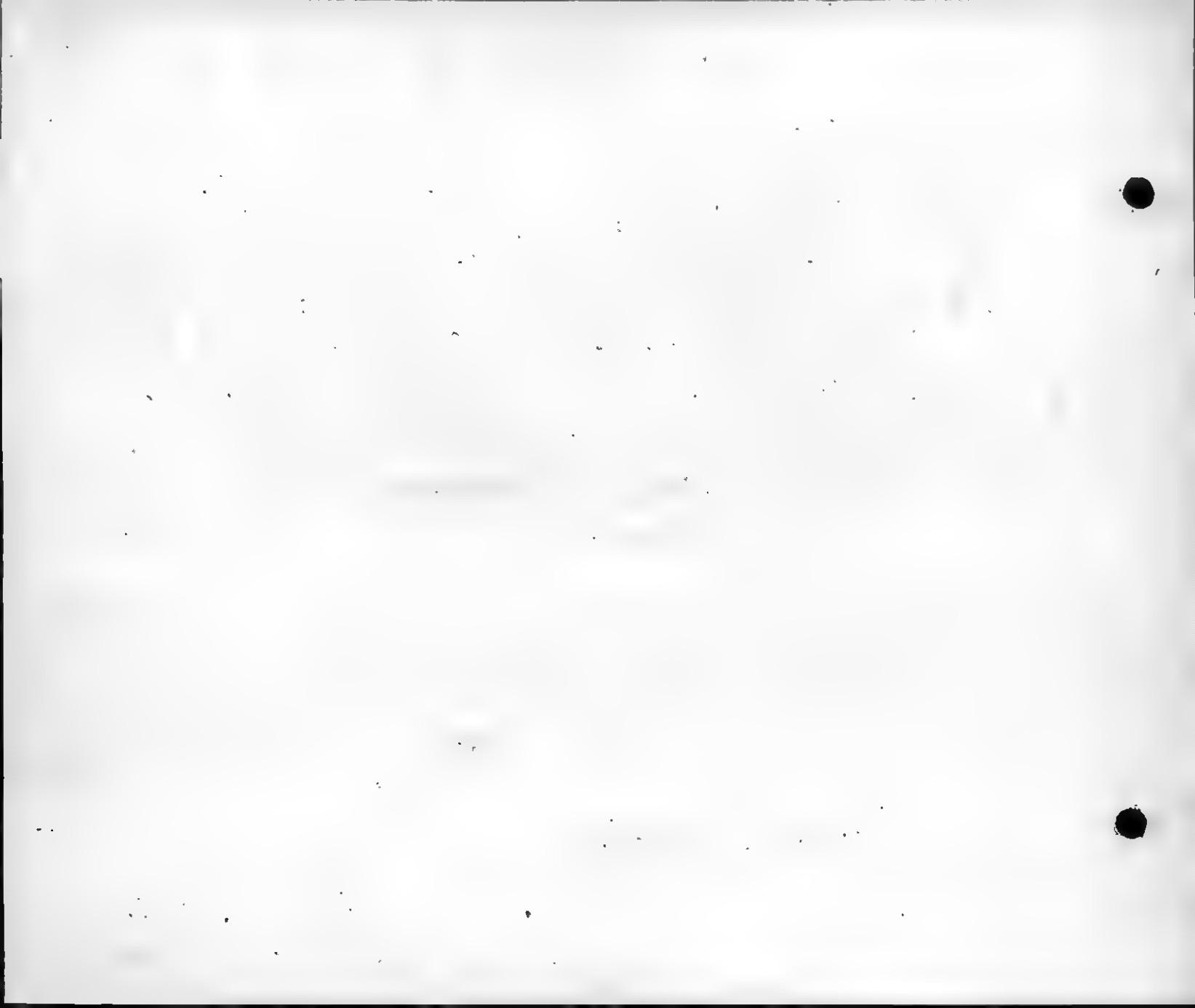
## CERTIFICATE OF DEATH

Reg. Dist. No.

06375

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
<i>Baltimore</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb <i>Rural</i>	
c. LENGTH OF STAY IN lb <i>6 weeks</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1234 Poplar Ave.</i>		d. STREET ADDRESS <i>1234 Poplar Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>William</i>	Middle <i>S.</i>
4. LAST NAME <i>Rice</i>		Last <i>Rice</i>	5. DATE OF DEATH <i>Jan. 22, 1960</i>
6. SEX <i>Male</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. AGE (In years last birthday) <i>71 yrs.</i>
9. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>		10. IF UNDER 24 HRS Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Blow</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Field</i>	
11. BIRTHPLACE (State or foreign country) <i>Baltimore</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>William S. Rice</i>		14. MOTHER'S MAIDEN NAME <i>Eda M. Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO INFORMANT <i>Mr. Wilderd E. Brown 1234 Poplar Ave.</i>	
17. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>minutes?</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary Occlusion	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Arteriosclerotic Cardio-Vasc Disease	
DUE TO (b) DUE TO (c)		Over 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 1960, to Jan 22, 1960, that I last saw the deceased alive on Jan 21, 1960, and that death occurred at 2 p.m. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED <i>3322 Frederick Ave. 1/23/60</i>	
ACTUAL SIGNATURE <i>Abram Goldman M.D.</i>		22a. BURIAL CREMATION REMOVAL (Specify) <i>Cremation</i>	
PHYSICIAN'S NAME (Type) <i>ABRAM GOLDMAN, M.D.</i>		22b. DATE THEREOF <i>1/26/60</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Woodlawn Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John G. Glavin</i>		24a. REC'D BY REGISTRAR DATE JAN 25 '60	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

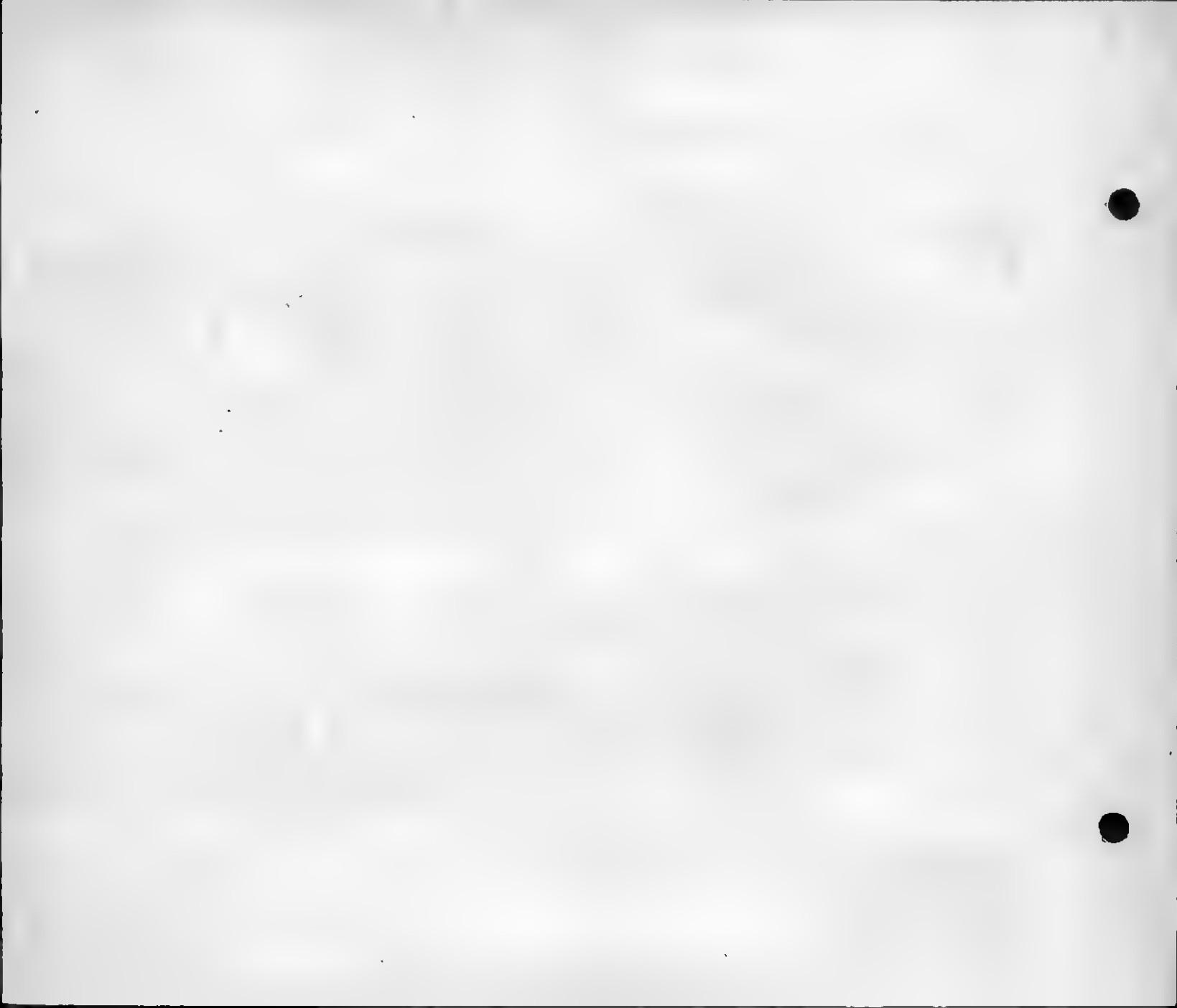
Item 4 13 1955 2-5-60 et  
0389

## CERTIFICATE OF DEATH

Reg. Dist. No.

00376

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>VILLA NOVA.</b>		c. LENGTH OF STAY IN 1b <b>1 1/2 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>AUGSBURG HOME</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTO, MD.</b>	
3. NAME OF DECEASED (Type or print) <b>LINNA</b>		d. STREET ADDRESS <b>4416 Parkmont Ave</b>	
4. DATE OF DEATH <b>JAN - 27</b>		Month <b>Jan</b>	Day <b>27</b>
5. SEX <b>M.</b>		6. COLOR OR RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>SEPR 28 1879</b>		9. AGE (In years from birthday) <b>81 80rs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>		12. CITIZEN OF WHAT COUNTRY? <b>Address</b> <b>6811 Campfield Rd</b>	
13. FATHER'S NAME <b>MOSES</b>		14. MOTHER'S MAIDEN NAME <b>Jennie Cane</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>(1) - Influenza</b> DUE TO <b>481X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. <b>(b) (2) - Cerebral Sclerosis Heart Disease</b> DUE TO <b>(c) Old cerebral hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Generalized cerebral sclerosis</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept.</b> , 19 <b>57</b> , to <b>Jan - 27</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>Jan - 27</b> , 19 <b>60</b> , and that death occurred at <b>BALTO</b> , M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>Earl L. Chemborg</b>		ADDRESS (Street, city or town, state) <b>M.D. 4108 Liberty St. BALTO, MD. 2-2970</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 2/1/60</b>		22b. DATE THEREOF <b>—</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Takwood Cem.</b>		22d. LOCATION (City, town, or county) <b>BALTO MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.A. Deemans 6067 Hayford Rd</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 2 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

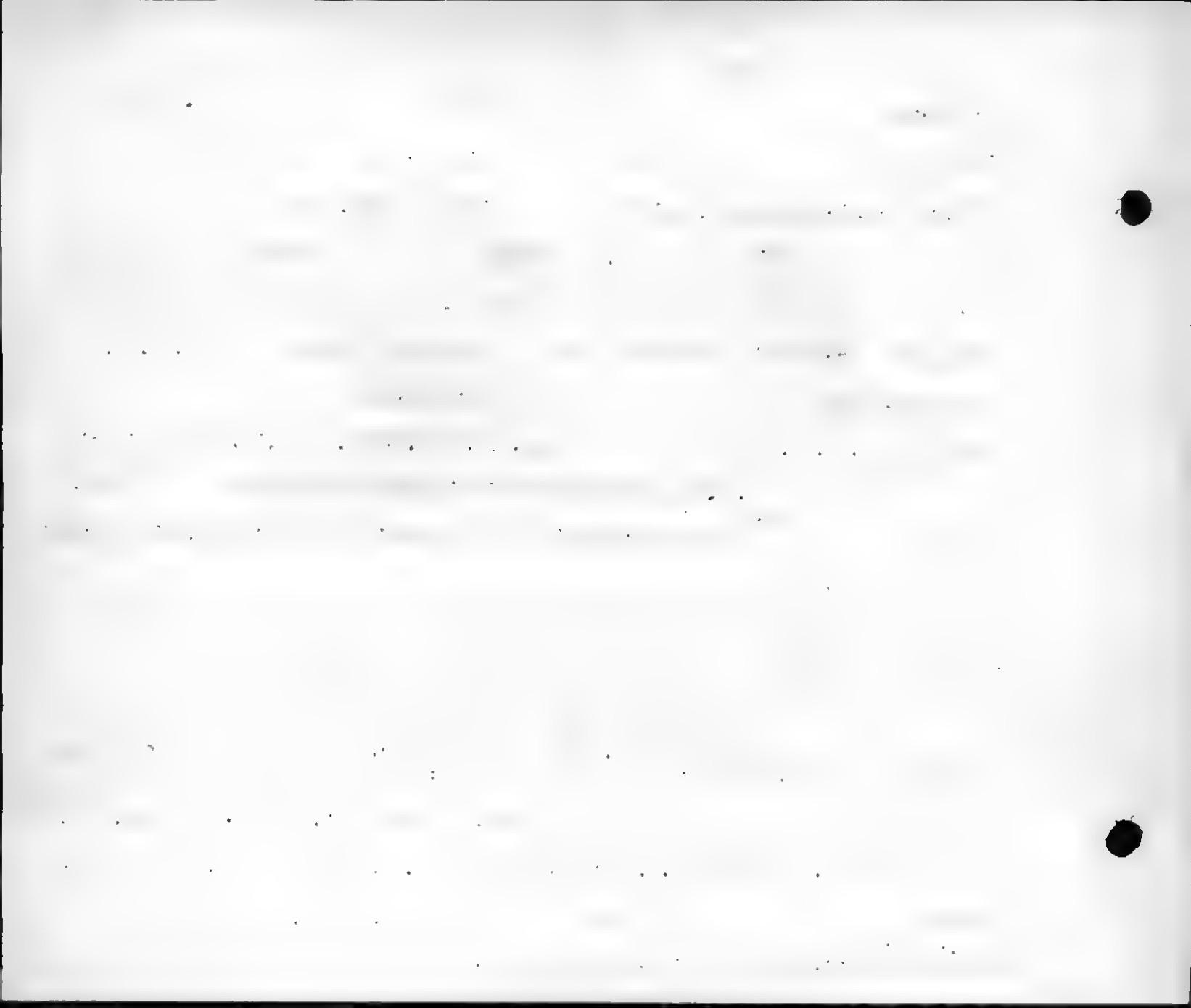
Item 2 File 254 1-20-60 et

## CERTIFICATE OF DEATH

116377

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o. STATE <b>Maryland</b>		b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>86 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Linkwood</b>		d. STREET ADDRESS <b>Merrick Conv. Home Rt. 50</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>JOSEPH</b>	Middle <b>M.</b>	Last <b>ROBINSON</b>	4. DATE OF DEATH <b>January 12 1960</b>	Month <b>January</b>	Day <b>12</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1878</b>	9. AGE (In years old birthday) <b>81 yrs.</b>	IF UNDER 1 YEAR Months <b>1</b>	IF UNDER 24 HRS Days <b>81</b>	Hours Min. <b>00</b>
10a. US/CAN OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Repair -Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Self employed</b>		11. BIRTHPLACE (State or foreign country) <b>Cambridge, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Josiah Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Marshall</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>S. A. W.</b>		INFORMANT <b>Clin.Rec., VAH, Balto. 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>42.1</b> <b>XXXX</b>		CORONARY OCCLUSION WITH MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		MARKED ARTERIOSCLEROSIS OF BRAIN WITH BRAIN ATROPHY UNKNOWN					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct. 18, 1959</b> , to <b>Jan. 12, 1960</b> , and that death occurred at <b>2:20 AM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state)		DATE SIGNED	
ACTUAL SIGNATURE <i>John W. Crawford</i>				M.D. VAH, FT. HOWARD DIV. BALTIMORE 18, MD. 1/12/60			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D. VAH, BALTO 18, MD.</b>		20f. FORT HOWARD DIVISION 1/12/60					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-14-60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Dorchester Memorial Park</b>		22d. LOCATION (City, town, or county) <b>Cambridge, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth L. Horner</i>		ADDRESS <b>Kenneth Thomas, Locust Street, Cambridge, Md.</b>		24a. REC'D. BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Francis</i>	



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

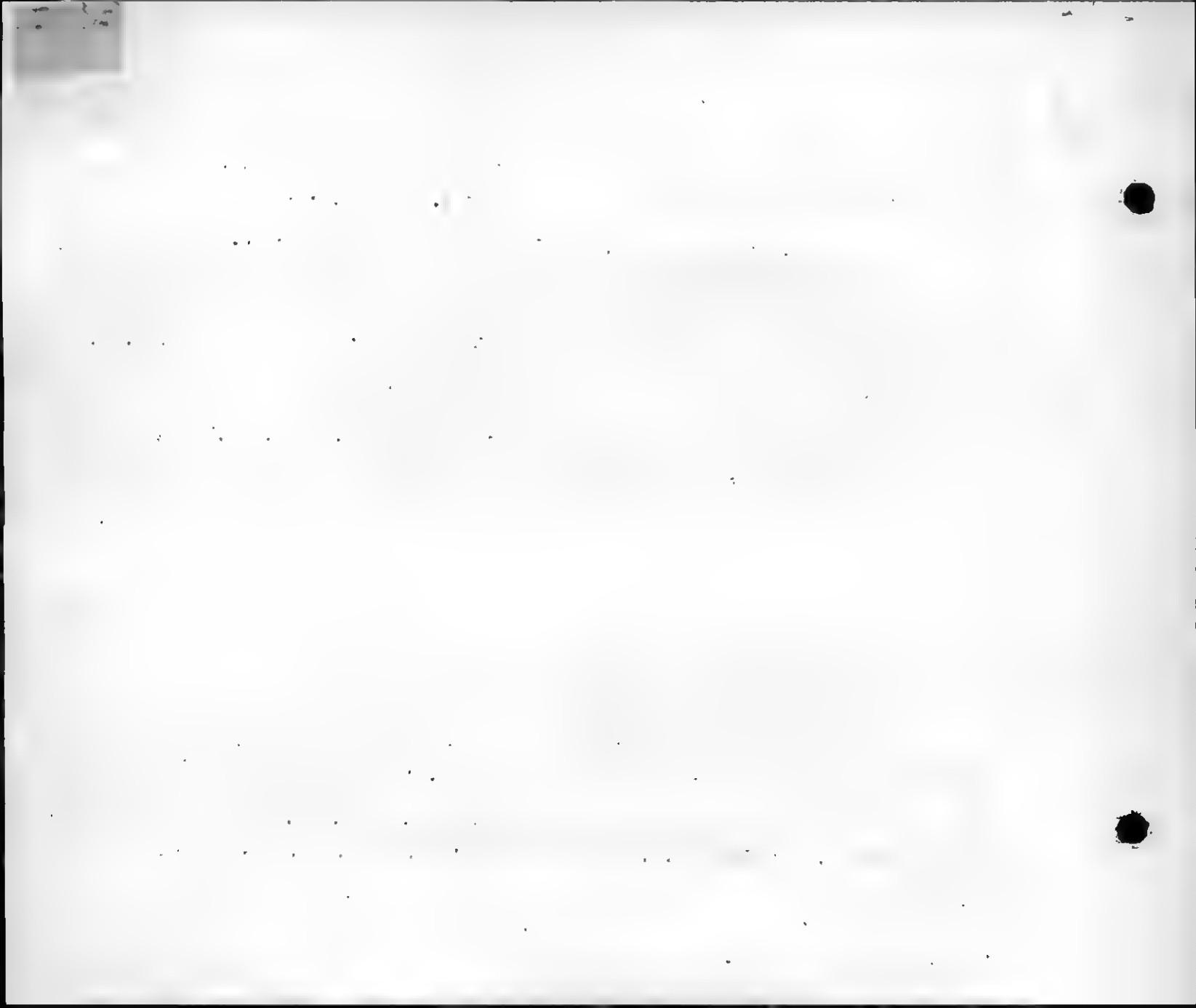
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0391 CERTIFICATE OF DEATH

Reg. Dist. No.

06378

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Residence before admission) o STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN lb <b>42 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		(15) <i>2101 4</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>4005 W. Belvedere Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <b>WILLIAM</b>	Middle <b>P.</b>	Last <b>ROMMAL</b>	4. DATE OF DEATH <b>January</b>	Month <b>15</b>	Day <b>Year</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>January 22, 1894</b>	9. AGE (In years at birthday) <b>65 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>City</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>William E. Rommal</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Murray</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>219-30-2958</b>		INFORMANT <b>Clin. Rec. VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b>		491X		INTERVAL BETWEEN ONSET AND DEATH <b>2 Days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <b>HODGKIN'S DISEASE</b>		500X		20 Months				
DUE TO (c)								
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>		(County) <b>1/15/60</b>
21. I certify that I attended the deceased from <b>December 4, 1959</b> to <b>January 15, 1960</b> , and that death occurred at <b>1:35 P.M.</b> from the causes and on the date stated above.								(State)
ACTUAL SIGNATURE <i>John W. Crawford Jr.</i>						ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>		DATE SIGNED <b>1/15/60</b>
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/19/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickner and Sons, Inc.</b>		ADDRESS North & Penna. <b>Aves. Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 18 '60</b>		24b. REGISTRAR'S SIGNATURE <i>John S. Thomas</i>		
VS A15 (4) 15M 9/58								



**10 HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death - Page 4  
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**TO FUNERAL DIRECTOR:** After this certificate has been signed by the offending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 File #254 1-20-60 et  
0223 CERTIFICATE OF DEATH

Reg. Dist. No. 00379

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk 22		c. LENGTH OF STAY IN lb 9 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3549 McShane Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Angelo	Middle +++++	Last Scarpulla
4. DATE OF DEATH	Month January	Day 12th	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1892
9. AGE (In years (last) birthday) yrs. 67	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stone Mason	11. KIND OF BUSINESS OR INDUSTRY Building	12. BIRTHPLACE (State or foreign country) Italy
13. FATHER'S NAME Frank Scarpulla		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO 216-07-4933	17. INFORMANT Frank Scarpulla	Address same as #2
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) Arteriosclerotic and Hypertensive Heart Disease (c)			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-8, 1960, to 1-11, 1960, that I last saw the deceased alive on 1-11-, 1960, and that death occurred at 80731 M.D. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE J. Hinno M.D. Mortification Road 2900 Dunran Rd /14/60			
PHYSICIAN'S NAME (Type) J. Hinno Baltimore 22, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1/16/60	22c. NAME OF CEMETERY OR CREMATORIUM St. Stanislaus Cemetery	22d. LOCATION (City, town, or county) (State) Baltimore, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley Jr.		ADDRESS Dundalk 22	24a. REC'D BY REGISTRAR DATE JAN 18 '60
			24b. REGISTRAR'S SIGNATURE O. H. S. Kline



X

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**to be filed by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

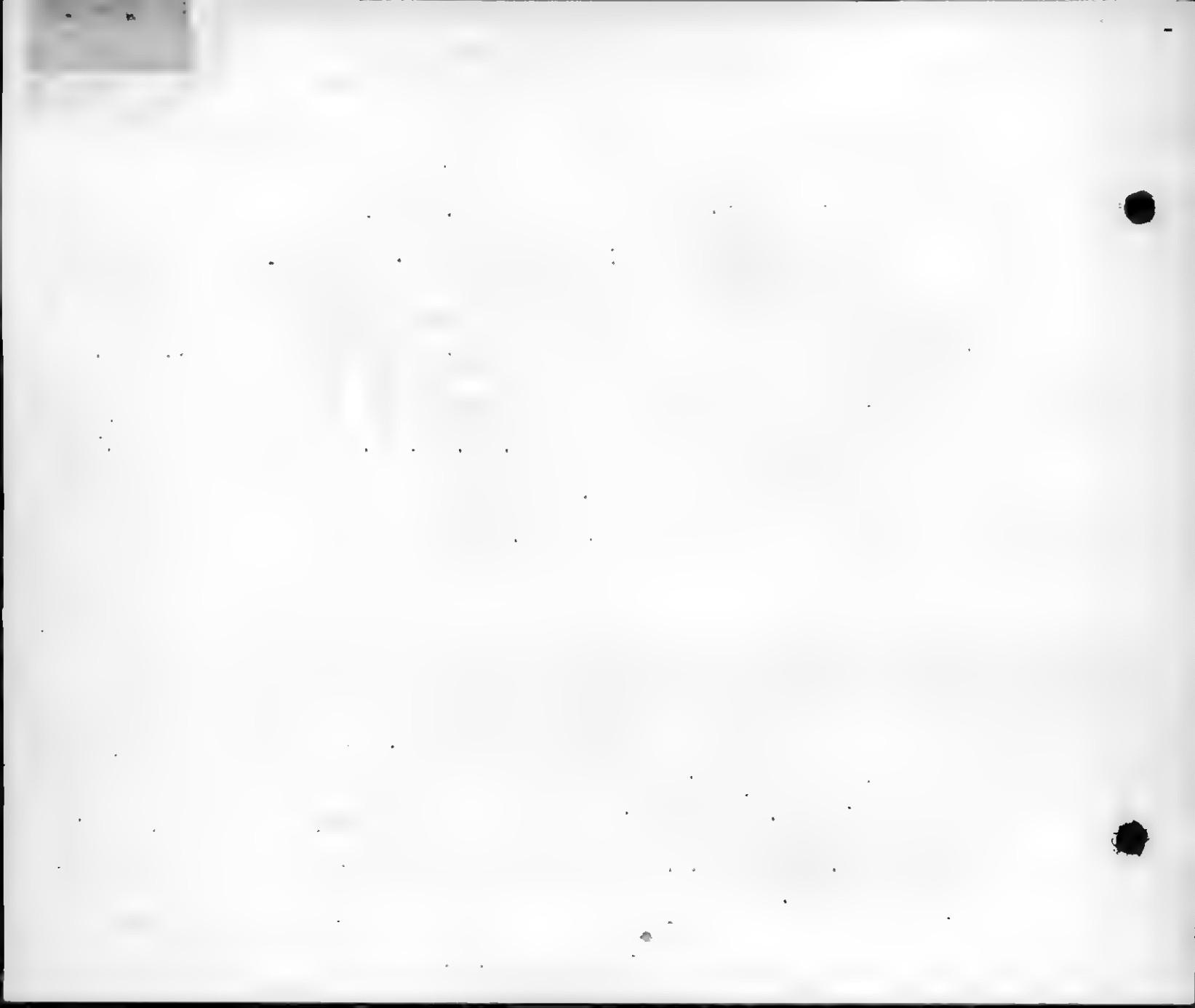
0392

## CERTIFICATE OF DEATH

Reg. Dist. No.

00380  
0380

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>Maryland</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>33 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore (21)</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>121 N. Curley Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>EDWARD</b>	Middle <b>Charles</b>	Last <b>SCHAFFER Sr.</b>	4. DATE OF DEATH	Month <b>January</b>	Day <b>7</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/88</b>	9. AGE (In years last birthday) <b>71 yrs</b>	IF UNDER 1 YEAR Months <b>7</b>	IF UNDER 24 HRS Days <b>050</b>	Hours <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Distillery</b>		11. BIRTHPLACE (State or Foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Henry Schafer</b>				14. MOTHER'S MAIDEN NAME <b>Mary Heise</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW I 213-01-1017</b>		INFORMANT <b>Clin. Rec. Vet. Adm. Hosp., Balto. 18, Md., Ft. Howard/</b>		Address <b>Digision</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <i>551A</i>						INTERVAL BETWEEN ONSET AND DEATH <b>1 MONTH</b>	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>		DUE TO (b) <b>CEREBRAL ARTERIOSCLEROSIS</b>				UNKNOWN	
DUE TO (c) <b>CEREBRAL ARTERIOSCLEROSIS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day Year Hour a. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <b>I</b> attended the deceased from <b>December 5, 1959</b> , to <b>January 7, 1960</b> , and that death occurred at <b>2:20 AM</b> , from the causes and on the date stated above.						ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>John W. Crawford</i>						DATE SIGNED <b>1/7/60</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimmeek (Charles E.)</b>		ADDRESS <b>3331 Brehm's Lane, Balto. Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 8 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krause</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4  
 may be ret'd.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

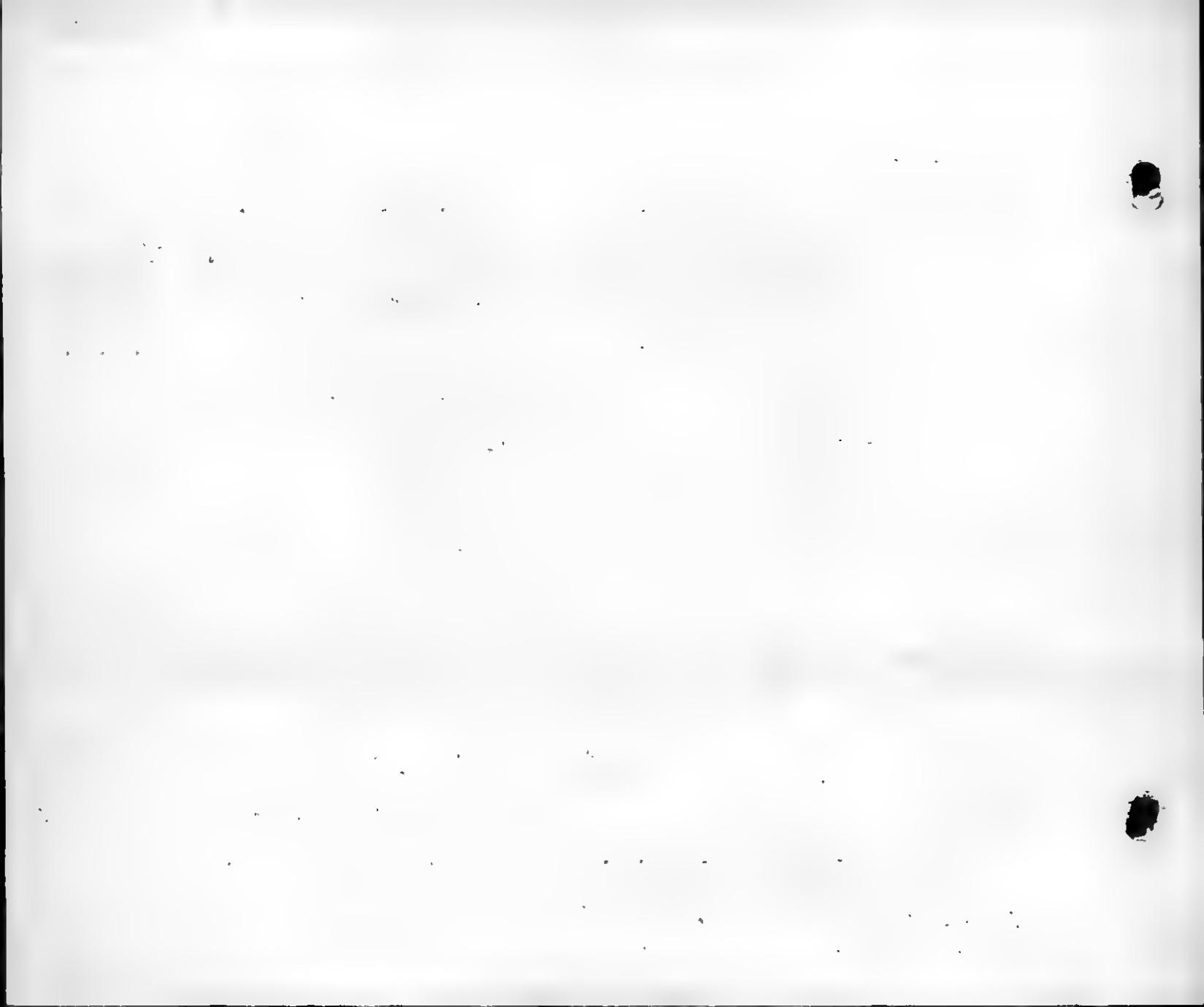
0393

## CERTIFICATE OF DEATH

Reg. Dist. No.

00381

1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 2yr9mthldy		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS 106 S. Franklintown Rd.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Horton	Last Schaub	4. DATE OF DEATH	Month January	Day 25	Year 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1897	9. AGE (In years last birthday) 69 yrs	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY Opewcay		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Schaub		14. MOTHER'S MAIDEN NAME Barbara Geiffin.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war & dates of service) C-887 625		16. SOCIAL SECURITY NO. Unknown		INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b)                          DUE TO Chronic mitral stenosis (c)                          DUE TO Chronic rheumatic heart disease  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24, 1957, to Jan. 25, 1960, that I last saw the deceased alive on Jan. 25, 1960, and that death occurred at 9:15AM, from the causes and on the date stated above. ACTUAL SIGNATURE Stella Wachsler M.D.							
ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL 1-86-60							
DATE SIGNED							
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.		Catonsville 28, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/29/60		22c. NAME OF CEMETERY OR CREMATORIUM Bethel Memorial Cemetery		22d. LOCATION (City, town, or county) Baltimore, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Otto B. Neupert - 1300 Eutaw Pl.		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	
VS A15 (4) 15M 9/■		DATE JAN 29 '60					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

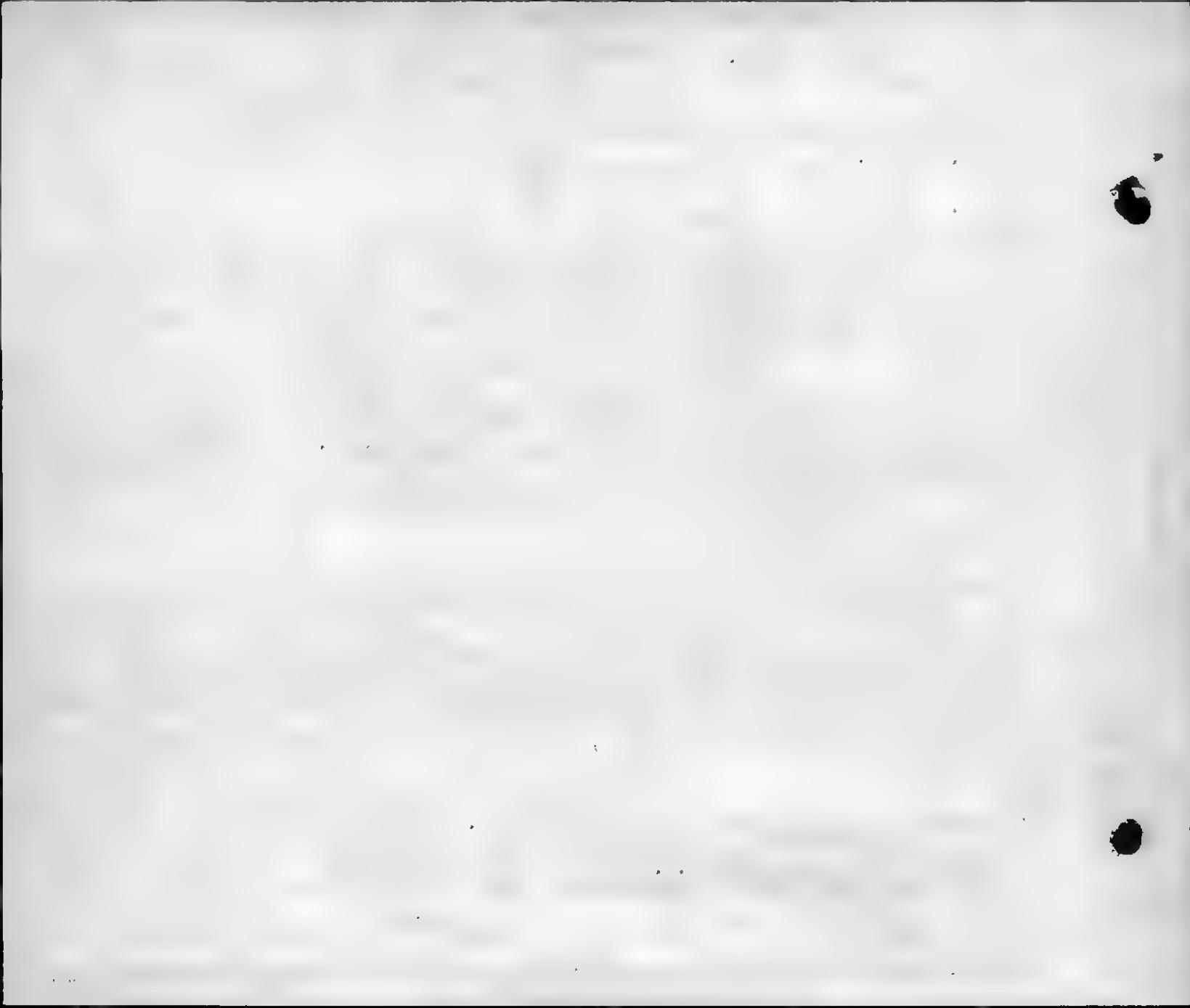
## CERTIFICATE OF DEATH

Reg. Dist. No.

32

00382

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u>		b. COUNTY <u>BALTIMORE CO</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Wilson, Maryland</u>		c. LENGTH OF STAY IN lb <u>2 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNN LK</u>		d. STREET ADDRESS <u>7013 CONLEY STREET</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Wilson State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <u>MARGARET</u>	Middle <u>LILLIAN</u>	Last <u>SCHELL</u>	4. DATE OF DEATH <u>JANUARY 3 1960</u>	Month	Day	Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/15/27</u>	9. AGE (In years last birthday) <u>32 yrs.</u>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Hours	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>	11. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	12. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	13. CITIZEN OF WHAT COUNTRY? <u>USA.</u>
13. FATHER'S NAME <u>PAUL B. SCHELL</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE MYERS</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO <u>214-24-8891</u>		17. INFORMANT <u>Hospital Records, Mt. Wilson State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY TUBERCULOSIS</u> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>22 YEARS.</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		(b) DUE TO		(c)							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)				
21. I certify that I attended the deceased from <u>6/18</u> , 19 <u>57</u> to <u>1-3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-3</u> , 19 <u>60</u> , and that death occurred at <u>8:24 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Mt. Wilson, Maryland</u>											
DATE SIGNED <u>Charles S. Newcomer, M.D.</u>											
ACTUAL SIGNATURE <u>William Newcomer, M.D.</u>		Superintendent									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>1-7-60</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>SACRED HEART CEM</u>		22d. LOCATION (City, town, or county) <u>GERMAN HILL RD, MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Newcomer, 701 S. CONKLING ST.</u>		ADDRESS <u>BALTO. 24 MO</u>		24a. REC'D BY REGISTRAR <u>C. J. Kline</u>		24b. REGISTRAR'S SIGNATURE <u>C. J. Kline</u>					
VS A15 (4) 15M 9/55		DATE JAN 8 '60									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00383

0395

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTO</b>		2. USUAL RESIDENCE (Where deceased lived, if institution- residence before admission) a. STATE <b>MD</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ESSEX</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>31 STEMMERS RUN RD</b>		e. STREET ADDRESS <b>31 STEMMERS RUN RD</b>	
3. NAME OF DECEASED (Type or print) <b>GERARD</b>		First <b>M.</b>	Middle <b>M.</b>
4. DATE OF DEATH Month <b>JAN.</b> Day <b>13</b> Year <b>1960</b>		Last	Month
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>SEPT. 10-1903</b>		9. AGE (In years last birthday) <b>56 yrs.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>JANITOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>BALTO. CO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HENRY SCHENNING</b>		14. MOTHER'S MAIDEN NAME <b>ANNA FUNK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-05-4096</b>	
17. INFORMANT <b>BARBARA (WIFE) SAME AS ABOVE</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>CARCINOMA Lung</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year+</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO			
(c) DUE TO			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Cardiovascular Disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) White Nat white at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. (City or town) <b>JANUARY 13, 1960</b>		(County) <b>BALTO Co.</b> (State) <b>MD</b>	
21. I certify that I attended the deceased from <b>June</b> , 19 <b>59</b> to <b>January</b> , 19 <b>60</b> that I last saw the deceased alive on <b>JANUARY 13, 1960</b> and that death occurred at <b>3 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>John E. Gessner</b> <b>701 Eastern Ave. BALTO. MD.</b>	
ACTUAL SIGNATURE <b>John E. Gessner</b>		DATE SIGNED <b>John E. Gessner</b>	
PHYSICIAN'S NAME (Type) <b>John E. Gessner</b>			
22a. BURIAL, CREMATION, REBURIAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>JAN. 16-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>SACRED HEART</b>		22d. LOCATION (City, town, or county) <b>BALTO Co. MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John G. Connelly - 418 Eastern Ave. Easy</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
ADDRESS <b>John G. Connelly - 418 Eastern Ave. Easy</b>		24b. REGISTRAR'S SIGNATURE <b>Swing S. Kress</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

100384

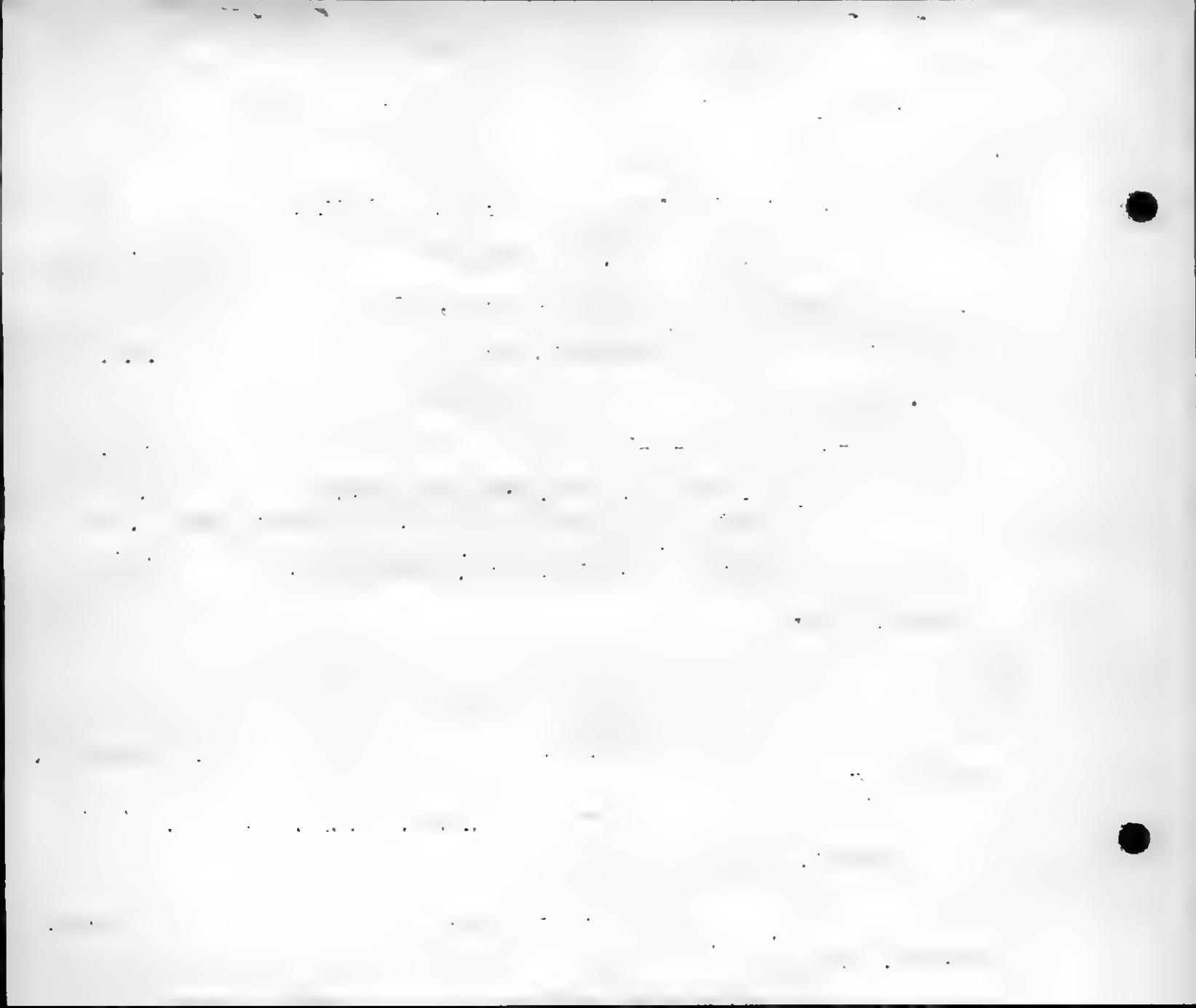
0396

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>11 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>G.</b>	4. DATE OF DEATH <b>JANUARY 31 1960</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 15, 1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRUCK DRIVER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ARUNDEL CONSTRUCTION CO.</b>	
10c. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN J. SCHMIDT</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET MILLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>217-16-6253</b>	INFORMANT Address <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MENINGITIS, ACUTE, TYPE UNDETERMINED</b> <b>XXX</b> HYPERTENSIVE HEART DISEASE WITH CONGESTIVE FAILURE RECENT			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>SURGICAL ABSENCE RIGHT 1st, 2nd, 3rd TOES</b> <b>XXX</b> TUMOR, TYPE UNDETERMINED, PAROTID GLAND OLD			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that <b>VA</b> attended the deceased from <b>January 20, 1960</b> , to <b>January 31, 1960</b> and that death occurred at <b>6:20 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Walter C. Goldstein</i>		ADDRESS (Street, city or town, state) <b>M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV.</b>	
DATE SIGNED <b>2/1/60</b>			
PHYSICIAN'S NAME (Type) <b>WALTER C. GOLDSTEIN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/5/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles K. Schimunek Funeral Home, Inc.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Ernest S. Kraus</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0397

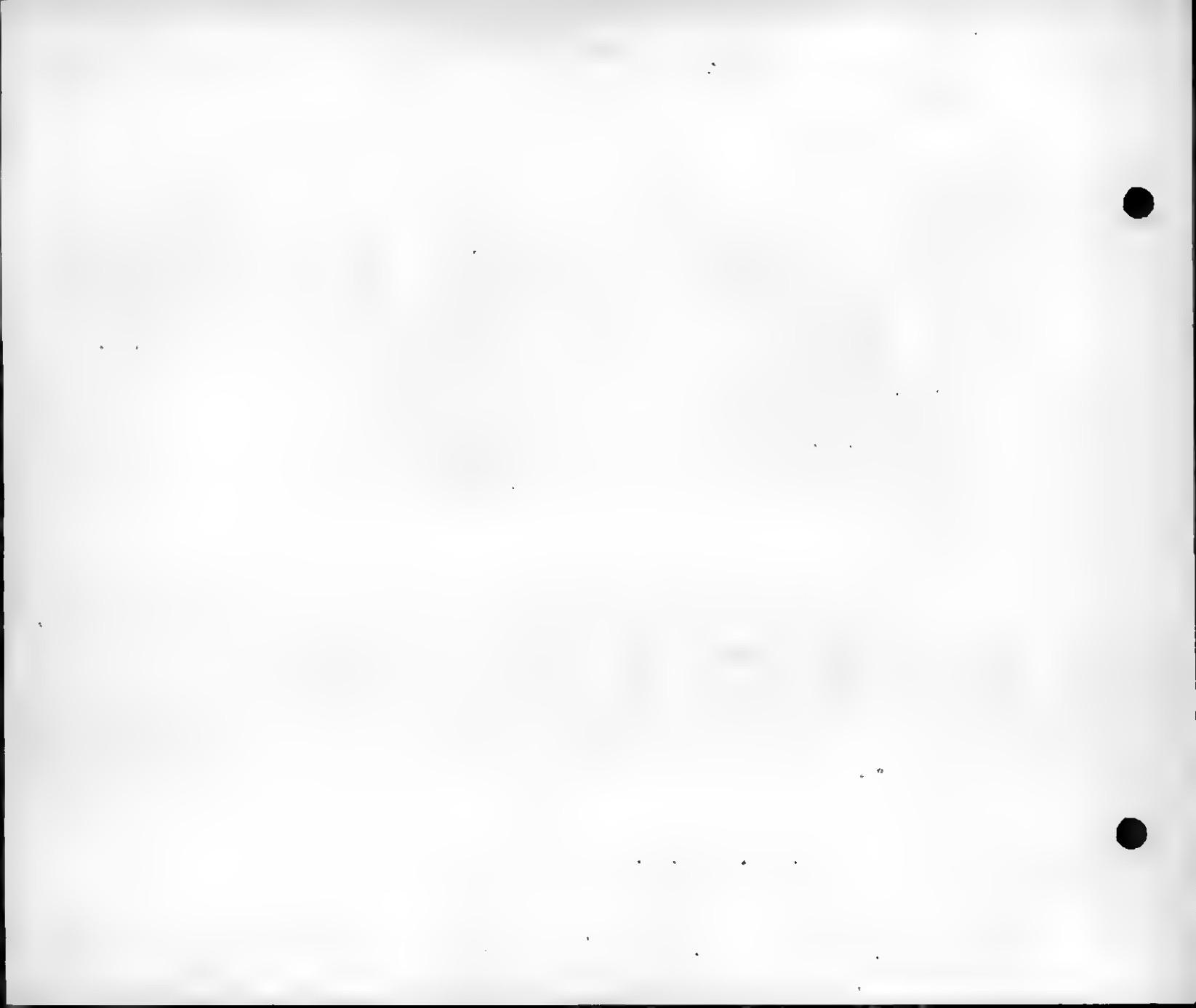
## CERTIFICATE OF DEATH

Reg. Dist. No. 00385

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catoonsville		c. LENGTH OF STAY IN 1b 3yrlmthl2dys	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First George	Middle Schubering	4. DATE OF DEATH January 3 1960
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 24, 1887
9. AGE (In years last birthday) 72 yrs.	10. JSUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12 CITIZEN OF WHAT COUNTRY? U. S. A.	13. FATHER'S NAME Gottfried Schubering		
14. MOTHER'S MAIDEN NAME Anna ?	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) yes W. W. I		
16. SOCIAL SECURITY NO. 214-20-9319-A	INFORMANT		Address SPRING GROVE STATE HOSPITAL
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  422.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.  (b) DUE TO Arteriosclerotic cardiovascular disease  (c) DUE TO Generalized arteriosclerosis, severe		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Dec. 28, 1959, to Jan. 3, 1960, that I last saw the deceased alive on Jan. 3, 1960, and that death occurred at 5:00 p.m., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) SPRING GROVE STATE HOSPITAL DATE SIGNED 1-4-60	
ACTUAL SIGNATURE Stella Wachsler	M.D.		
PHYSICIAN'S NAME (Type) Stella Wachsler, M. D.	Catonsville 28, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) Jan 3, 1960	22b. DATE THEREOF Jan 3, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Towson	22d. LOCATION (City, town, or county) An A. C. C. Inc.
23. FUNERAL DIRECTOR'S SIGNATURE P. Edward Evans, son 14005 Charles St (30)	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 5 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Thomas



14  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0224 CERTIFICATE OF DEATH

Reg. Dist. No. 1128A

1. NAME OF DECEASED  
(Type or Print)

William Selonkski

2. DATE OF DEATH

1-13-60

3. PLACE OF DEATH IN BALTIMORE, MARYLAND

FULL NAME OF  
HOSPITAL OR  
INSTITUTION

(If not in hospital or institution give street  
address or location)

Baltimore County  
8212 Longpoint Rd  
Towson MD

4. USUAL RESIDENCE (Where deceased lived if institution residence before admission)

A. STATE Maryland

B. COUNTY Baltimore

(If outside city limits, write RURAL and give township)

C. CITY OR TOWN

D. STREET ADDRESS

(If rural, give location)

18212 Longpoint Rd

5. SEX

6. COLOR OR RACE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)

George

10b. KIND OF BUSINESS OR INDUSTRY

Rheem Mfg Co

13. FATHER'S NAME

Joseph Selonkski

15. Was Deceased Ever in U.S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

1954-6-705

8. DATE OF BIRTH

Dec-8-1881

9. AGE (In years  
last birthday)

78

If Under 1 Year  
Months Days Hours Min

11. BIRTHPLACE (State or foreign country)

Lithuania

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A

14. MOTHER'S MAIDEN NAME

Marietta ?

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH

(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

17. INFORMANT

Julia Lomaxsey 8212 Longpoint Rd

ADDRESS

INTERVAL BETWEEN  
ONSET AND DEATH

CAUSE OF DEATH

(A) Acute coronary

oedema

Chronic heart failure

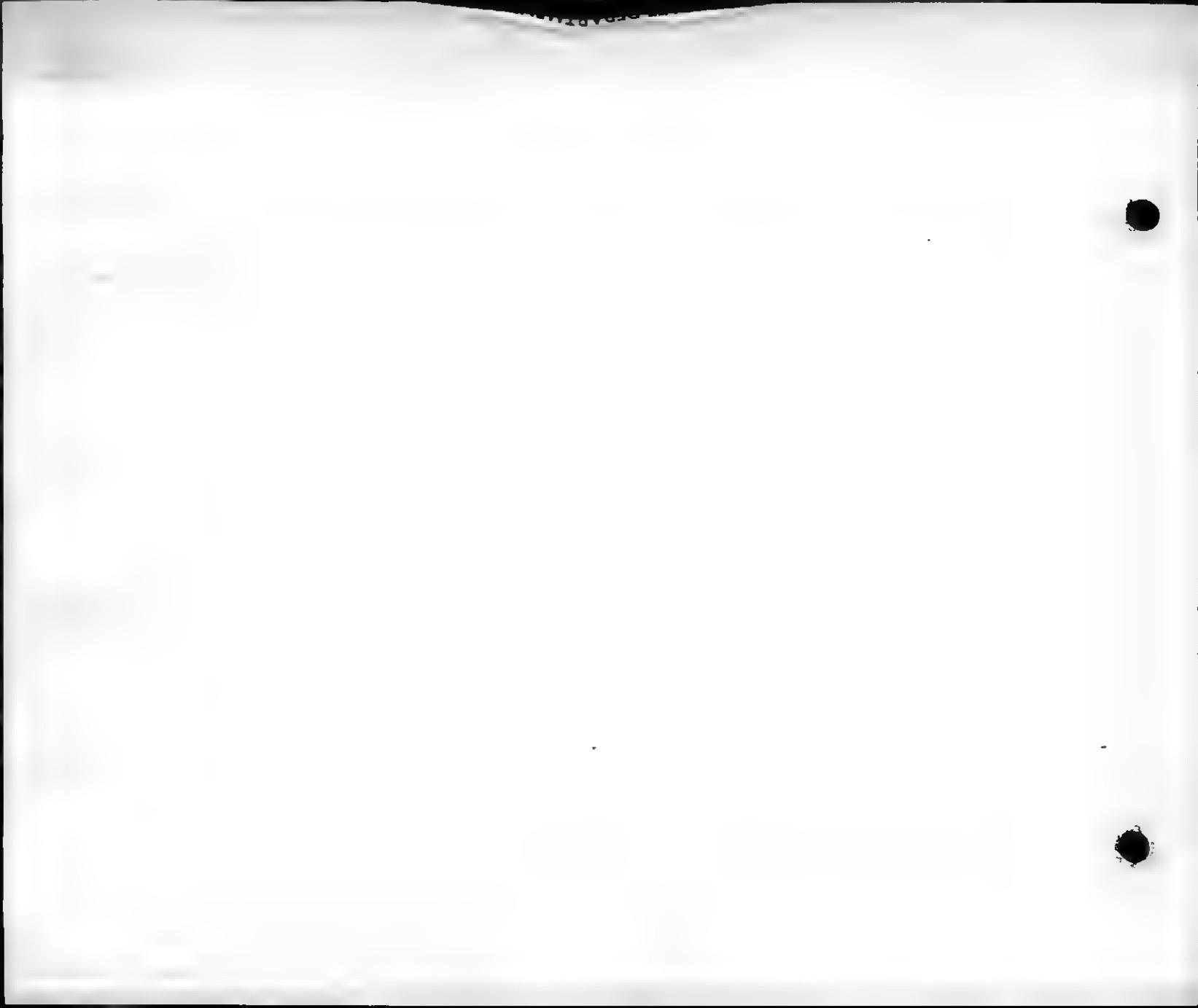
Arteriosclerosis

19. CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19a. DATE OF OPERATION



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

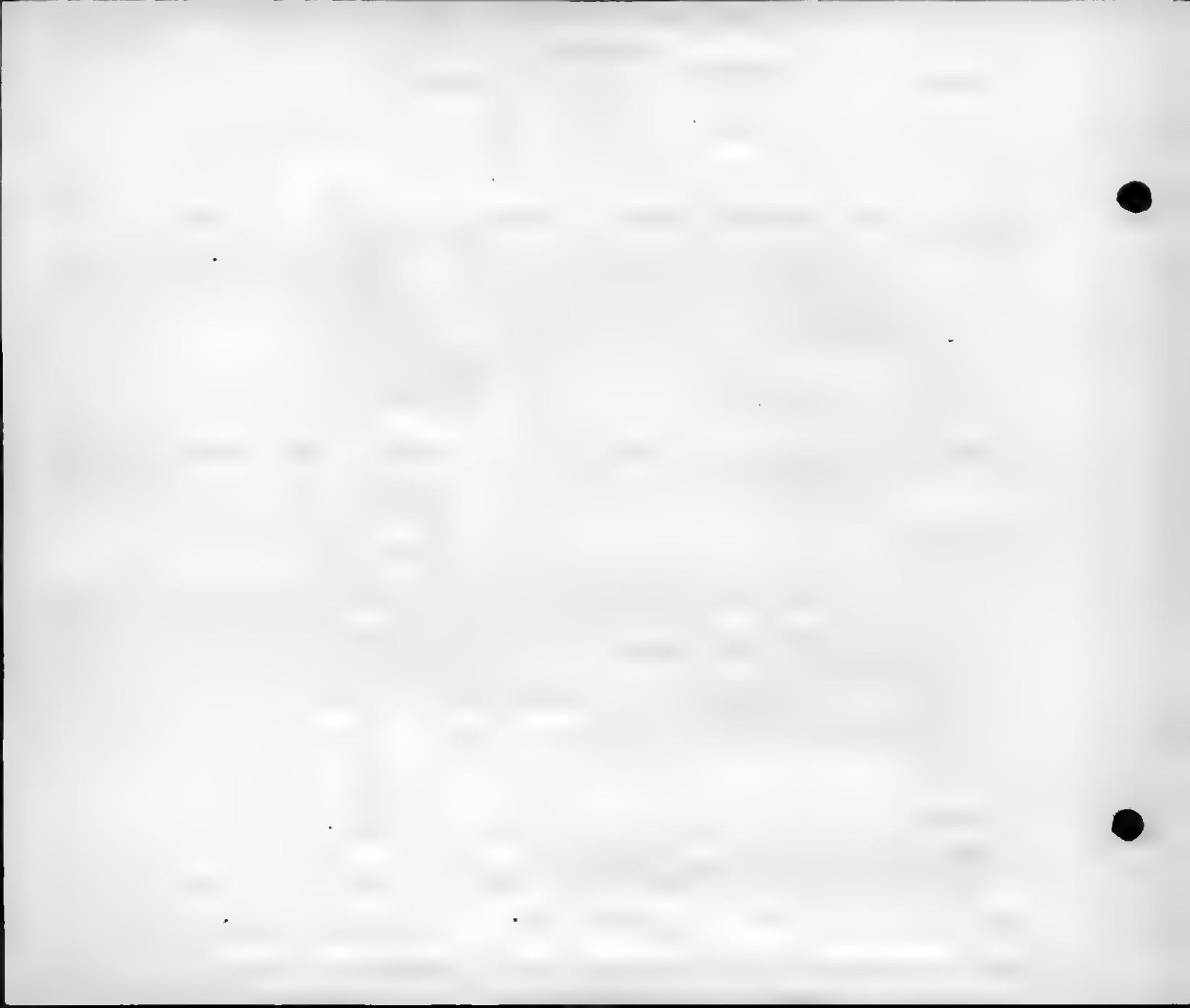
Reg. Dist. No.

00387

1. PLACE OF DEATH a. COUNTY <i>BALTO.</i>		0335 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>BALTO.</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - WOODLAWN</i>		c. LENGTH OF STAY IN 1b <i>36 YEARS</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>RURAL</i>		d. STREET ADDRESS <i>7312 WINDSOR MILL Rd.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>7312 WINDSOR MILL Rd.</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)		First <i>EDWARD</i>	Middle <i>GOULDY</i>	Last <i>SHAWN</i>	4. DATE OF DEATH <i>1/28/1884</i>	Month <i>Jan.</i>	Day <i>14,</i>	Year <i>1960</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/28/1884</i>	9. AGE (In years less birthday) yrs. <i>75</i>	10. IF UNDER 1 YEAR Months <i>75</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>SALESMAN</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>SALESMAN</i>		11. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		
13. FATHER'S NAME <i>JAMES SHAWN</i>		14. MOTHER'S MAIDEN NAME <i>AVIS SMITH</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>217-09-3110</i>		17. INFORMANT <i>WIFE - MRS. SHAWN</i>		Address <i>7312 WINDSOR MILL Rd</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>161X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				CARCINOMA OF LARYNX & METASTASES		INTERVAL BETWEEN ONSET AND DEATH <i>ONE YEAR</i>		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>JUNE 12, 1959</i> to <i>1/14, 1960</i> , that I last saw the deceased alive on <i>1/12, 1960</i> , and that death occurred at <i>8:05 AM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>8204 LIBERTY RD, BALTO, MD</i>								
ACTUAL SIGNATURE <i>Edwin L. Pierpoint</i>		M.D. <i>EDWIN L. PIERPOINT, MD</i>				DATE SIGNED <i>1/14/60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1/16/60</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Lorraine Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Woodlawn, Md.</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Sieker &amp; Sons - Balt. 17</i>		ADDRESS <i>111</i>		24a. REC'D BY REGISTRAR DATE <i>1/15 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Clyde S. Krebs</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

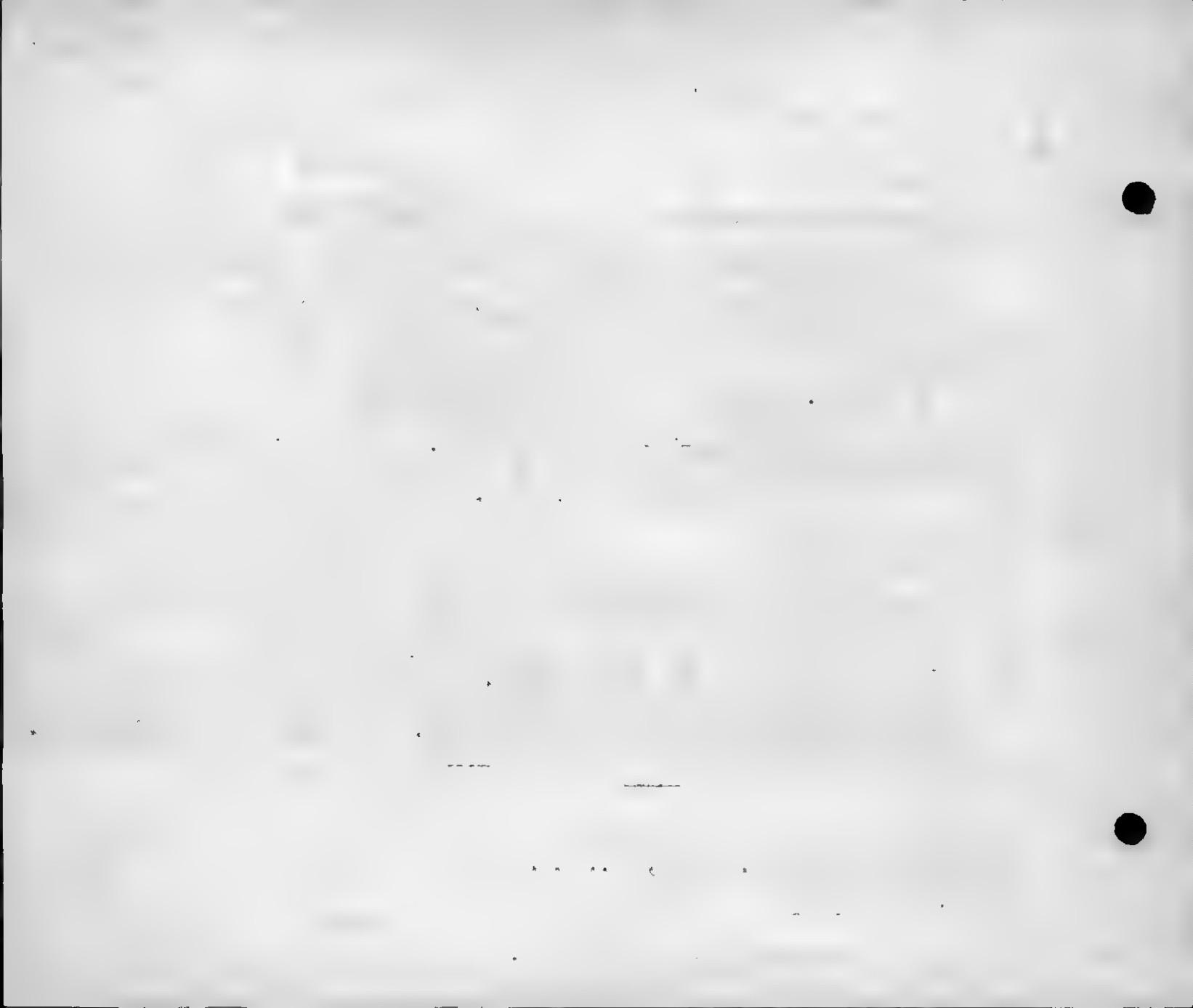


**FOR STATE  
HEALTH DEPT.**

**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 00388

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any cause of death is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>	0399	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <b>Maryland</b>	b. COUNTY
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Phoenix</b>	c. LENGTH OF STAY IN TB	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lutherville</b>	d. STREET ADDRESS <b>120W Ridgley Road</b>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>THOMAS EVANS</b>	First Middle Last	4. DATE OF DEATH <b>January 25 1960</b>	Month Day Year	5. SEX Male
6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/18/42</b>	9. AGE (in years) IF UNDER 1 YEAR 17 yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>
10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	13. FATHER'S NAME <b>Samuel E. Sheeler</b>	14. MOTHER'S MAIDEN NAME <b>Ruth Myers</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	16. SOCIAL SECURITY NO. <b>213-38-8345</b>	17. INFORMANT <b>Samuel E. Sheeler</b>	Address <b>above</b>	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound of Head.</b>
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. {	DUE TO (b)			INTERVAL BETWEEN ONSET AND DEATH
	DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Shot while hunting.</b>			
20c. TIME OF INJURY Hour <b>XX</b> 1:00 p.m.	Month, Day, Year <b>1/25 1960</b>	20d. INJURY OCCURRED Wh le at work <input type="checkbox"/> Not Wh le at work <input checked="" type="checkbox"/> <b>Loch Raven Res.</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Towson</b>	20f. (City or town) (County) (State) <b>Baltimore Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	CHIEF MEDICAL EXAMINER <input type="checkbox"/>	ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	DATE SIGNED <b>1/26/60</b>	
ACTUAL SIGNATURE <i>William V. Lovitt, Jr., M.D.</i>	M.D.	DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <b>William V. Lovitt, Jr., M.D.</b>	Address (Street, city, town, or county) <b>Sparks, Maryland</b>	22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-28-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Jessop Methodist</b>
23. FUNERAL DIRECTOR <b>Brooks Funeral Service, Towson 4, Md.</b>	ADDRESS <b>JAN 28 '60</b>	24a. REC'D BY REGISTRAR <b>Christen S. Krause</b>	24b. REGISTRAR'S SIGNATURE	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. 00389

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 1 should be forwarded to the Chief Medical Examiner's Office along with Form MA3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		0400 Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire		c. LENGTH OF STAY IN lb		X Berkshire		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berkshire		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7530 Berkshire Road				d. STREET ADDRESS 7530 Berkshire Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROY		First	Middle G.	Last SHIFFLETT	4. DATE OF DEATH January 13, 1960	Month	Doy	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH February 7, 1914	9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Shipyard		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Linwood Shifflett				14. MOTHER'S MAIDEN NAME Nettie Shifflett				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Roy W. Shifflett 201 Maple Ave-22		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]						INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		420.1 DUE TO Coronary Occlusion						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)						
		DUE TO						
		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19								
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>M. B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 1/14/60		
EXAMINER'S NAME (Type) M. B. Davis MD		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/15/60		22c. NAME OF CEMETERY OR CREMATORIUM Oak Lawn Cemetery		22d. LOCATION (City, town, or county) Colgate, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Ulrich Funeral Home Dundalk, Md.		ADDRESS		24a. REC'D BY REGISTRAR JAN 18 '60		24b. REGISTRAR'S SIGNATURE Curving S. Knott		
				DATE				



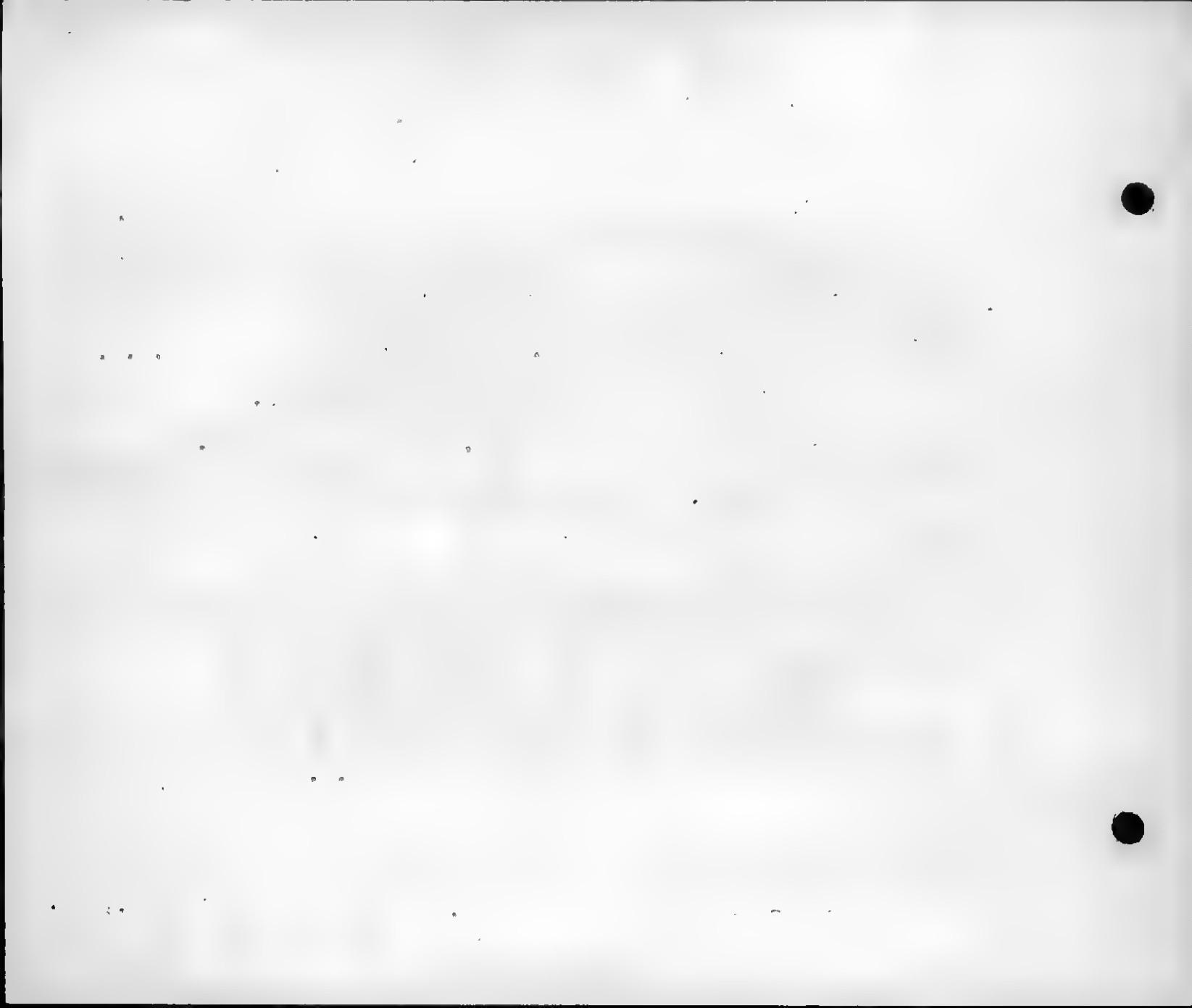
**TO HOSPITAL**  **ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

00390

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stemmers Run</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Stemmers Run</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1813 Sunnyside Lane # 21.</b>		d. STREET ADDRESS <b>1813 Sunnyside Lane # 21.</b>	
3. NAME OF DECEASED (Type or print) <b>DORA</b>		First <b>SMETON</b>	Middle Last 4. DATE OF DEATH <b>January 16, 1960.</b>
S. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1880</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Esskay Meat Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Germany</b>
13. FATHER'S NAME <b>Kreve</b>		14. MOTHER'S MAIDEN NAME <b>Unknown.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. -----	17. INFORMANT <b>Mary A. Schorr</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH <i>Cerebral vascular occlusion</i> <i>Transient</i> <i>Arteriosclerosis Under Vascular Disease 5 yrs</i>	
<b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> <i>4a</i> Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. <b>DUE TO</b> <i>4b</i> <b>DUE TO</b> <i>4c</i>		<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m.      Day p. m.      19 <b>20d. INJURY OCCURRED</b> While Not while of work <input type="checkbox"/> of work <input type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town)</b> (County) (State) <b>21. I certify that (I) (this hospital) attended the deceased from</b> <i>Jan 1 1960 to Jan 16 1960</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 16 1960</i> <b>and that death occurred at</b> <i>7:15 P.M.</i> <b>The causes and on the date stated above.</b> <b>22a. SIGNATURE</b> <i>John B. Bergman</i> <b>22c. PHYSICIAN'S NAME (Type)</b> <b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b> <b>23b. DATE THEREOF</b> <b>1-19-60.</b> <b>23c. NAME OF CEMETERY OR CREMATORIUM</b> <b>Sacred Heart Cem.</b> <b>23d. LOCATION (City, town, or county)</b> (State) <b>7401 German Hill Rd., Md.</b> <b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Charles S. Zeiler</i> <b>ADDRESS</b> <i>901 S. CONKLING ST.</i> <i>BALTIMORE, MD.</i> <b>25a. REC'D BY REGISTRAR</b> <b>JAN 20 '60</b> <b>25b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Kraus</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0402

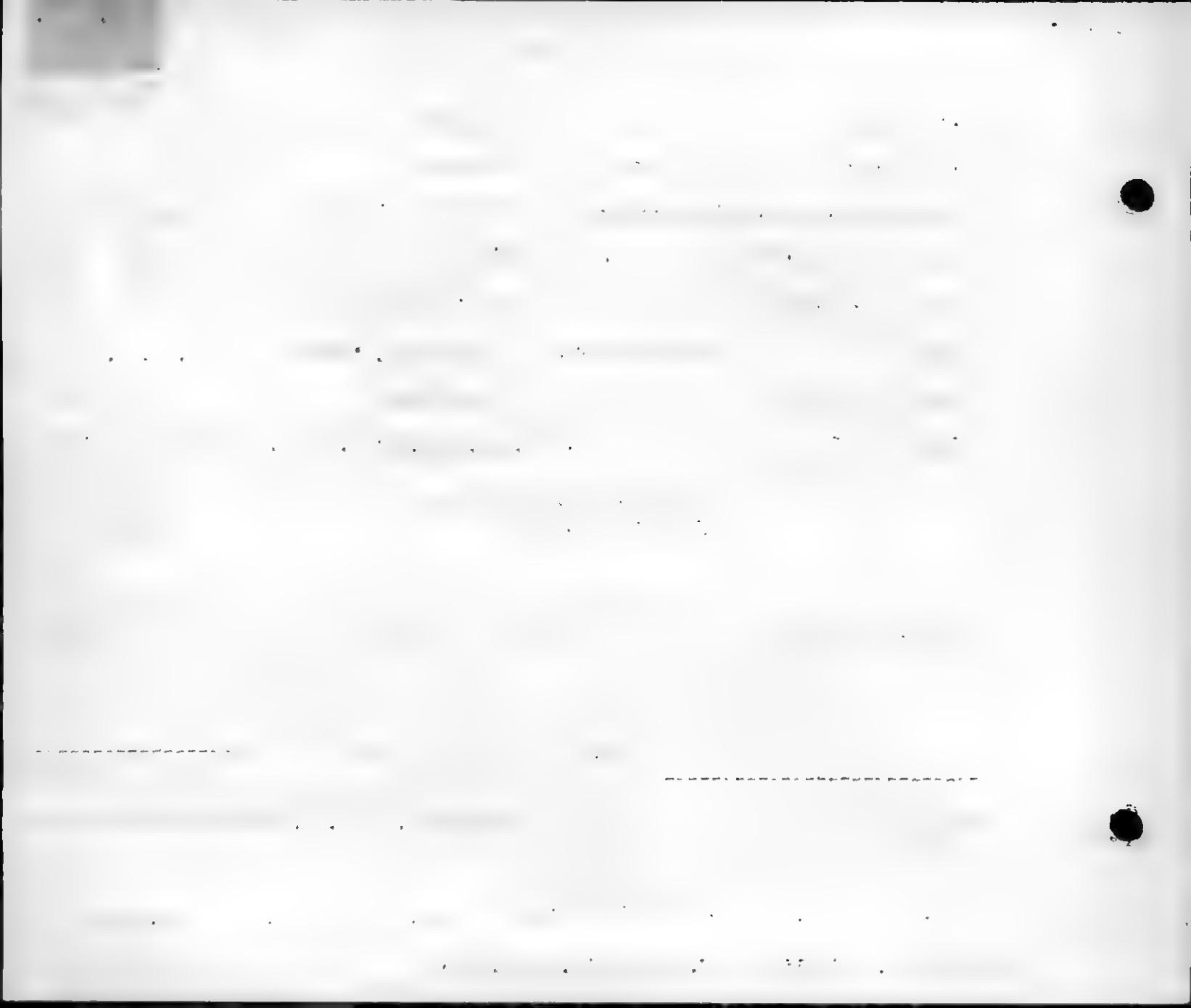
## CERTIFICATE OF DEATH

Reg. Dist. No. 00391

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>1528 Clifton Avenue (17)</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>DANIEL F. SMITH</b>		First	Middle	Last	4. DATE OF DEATH <b>January 28</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 22, 1895</b>	9. AGE (In years last birthday) <b>64 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seaman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Merchant Marine</b>		11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Maryland</b>		12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
13. FATHER'S NAME <b>Benjamin Smith</b>		14. MOTHER'S MAIDEN NAME <b>Eliza Chase</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		INFORMANT <b>Clin. Rec., VAH, Balto. 18, Md. Fort Howard Division</b>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1571 X</i>		CARCINOMATOSIS, ABDOMINAL CARCINOMA OF STOMACH				INTERVAL BETWEEN ONSET AND DEATH UNKNOWN		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO						UNKNOWN		
(c) DUE TO								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CACHEXIA, MODERATE</b>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <b>A</b> attended the deceased from <b>January 6, 1960</b> to <b>January 28, 1960</b> , and that death occurred at <b>7:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE: <i>H. J. Jaworski</i>						ADDRESS (Street, city or town, state)		
PHYSICIAN'S NAME (Type)						DATE SIGNED		
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 1, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cem.</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arlington S. Phillips</b>		ADDRESS <b>1808 N. Monroe St. Baltimore 17 Md.</b>		24a. RECD BY REGISTRAR <b>FEB 3 '60</b>		24b. REGISTRAR'S SIGNATURE <b>C. L. Phelan</b>		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0234

## CERTIFICATE OF DEATH

Reg. Dist. No.

00392

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>		c. LENGTH OF STAY IN 1b <i>4 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1101 Francis Ave</i>		d. STREET ADDRESS <i>1101 Francis Ave</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>James P. Smith Jr.</i>		First <i>James</i>	Middle <i>P.</i>	Last <i>Smith Jr.</i>	4. DATE OF DEATH Month <i>July</i>	Day <i>29</i>	Year <i>1960</i>
5. SEX <i>M.</i>	6. COLOR OR RACE <i>W/</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10 OCT 1886</i>	9. AGE (In years last birthday) <i>71 yrs.</i>	IF UNDER 1 YEAR Months <i>0</i>		IF UNDER 24 HRS Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Marine (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Hotel</i>		11. BIRTHPLACE (State or foreign country) <i>New York, N.Y.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>(Unknown) Smith</i>		14. MOTHER'S MAIDEN NAME <i>(Unknown)</i>		Address <i>8 and 13x</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>220-05-210</i>		17. INFORMANT <i>Mrs Frances Gruber</i>		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i>		DUE TO <i>Cardiac failure</i>		DUE TO <i>Arterio sclerosis generalized from arteriosclerosis</i>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <i>IP</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> or work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>3/29</i> , 1957, to <i>1/29</i> , 1960, that I last saw the deceased alive on <i>1/27</i> , 1960, and that death occurred at <i>12 PM</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>4605 5th MONSON AVE</i>		DATE SIGNED <i>AUG 13/60</i>					
ACTUAL SIGNATURE <i>Cliff Ratliffe Jr. M.D.</i>							
PHYSICIAN'S NAME (Type) <i>CLIFF RATLIFE JR.</i>		BALT 024, MD					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Cremation</i>		22b. DATE THEREOF <i>1 Feb 1960</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>London Park Crem</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>R. Washington</i>		ADDRESS <i>Glen Burnie, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 2 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Turner</i>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

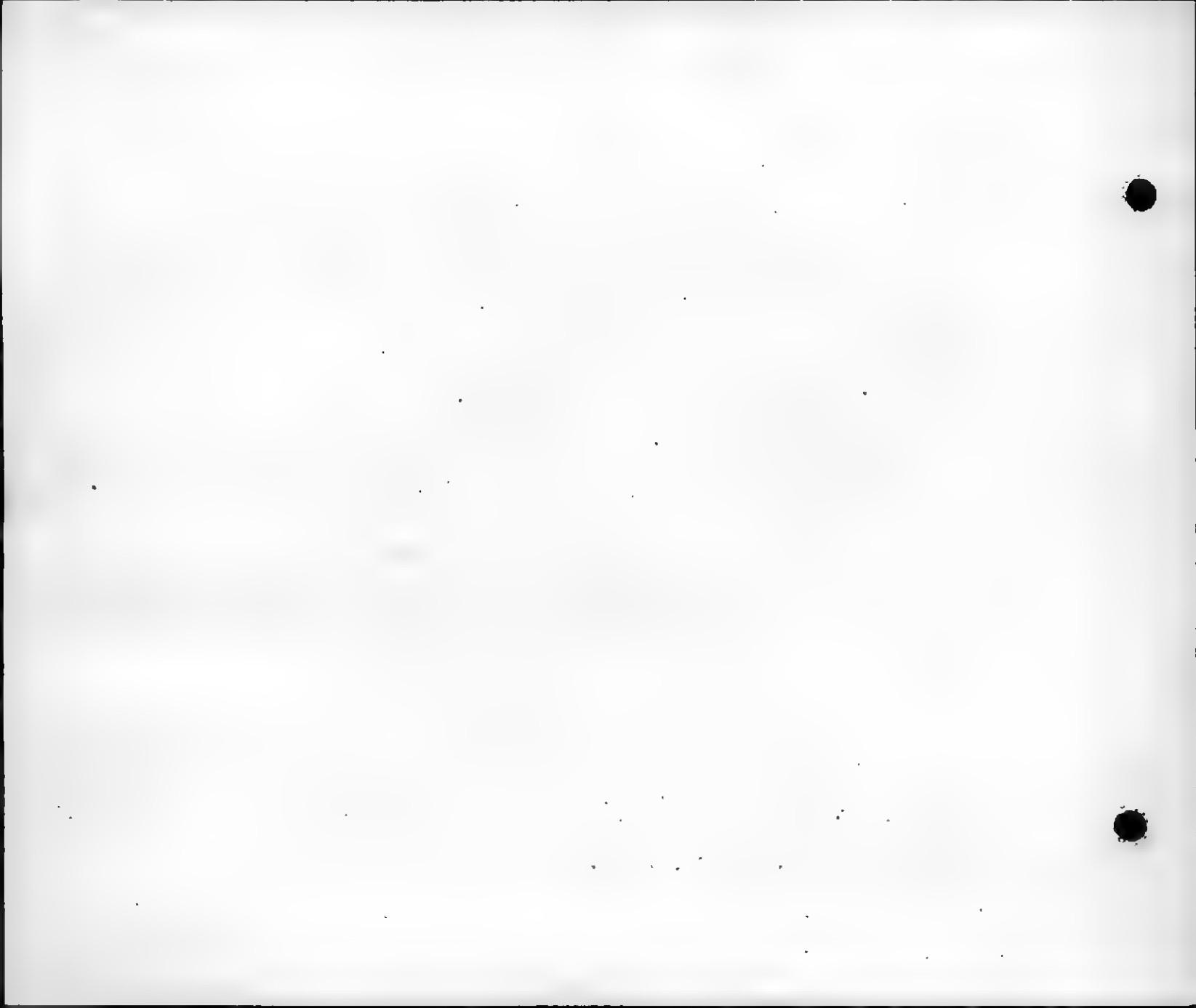
06393

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY  Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE  Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson, Baltimore		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Armacost Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SARAH	Middle RAY	Last Smith
4. DATE OF DEATH January 10, 1960	Month Jan	Day 10	Year 1960
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 25, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Daniel Osborn	14. MOTHER'S MAIDEN NAME Anna Akhurst		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	INFORMANT Family Records	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>AFTEROSCLEROTIC CARDIOVASCULAR DISEASE</i> DUE TO 4/20/1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO (c)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <i>William A. Pillsbury</i> DATE SIGNED <i>1-11-60</i> PHYSICIAN'S NAME (Type) William A. Pillsbury, M.D.			
22a. BURIAL, CREMATION, REMOVAL Burial	22b. DATE THEREOF Jan. 13, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Carrollton Church Cemetery	22d. LOCATION (City, town, or county) Finksburg, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE John Burns' Sons, Towson, Maryland	ADDRESS	24a. REC'D BY REGISTRAR JAN 15 '60	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

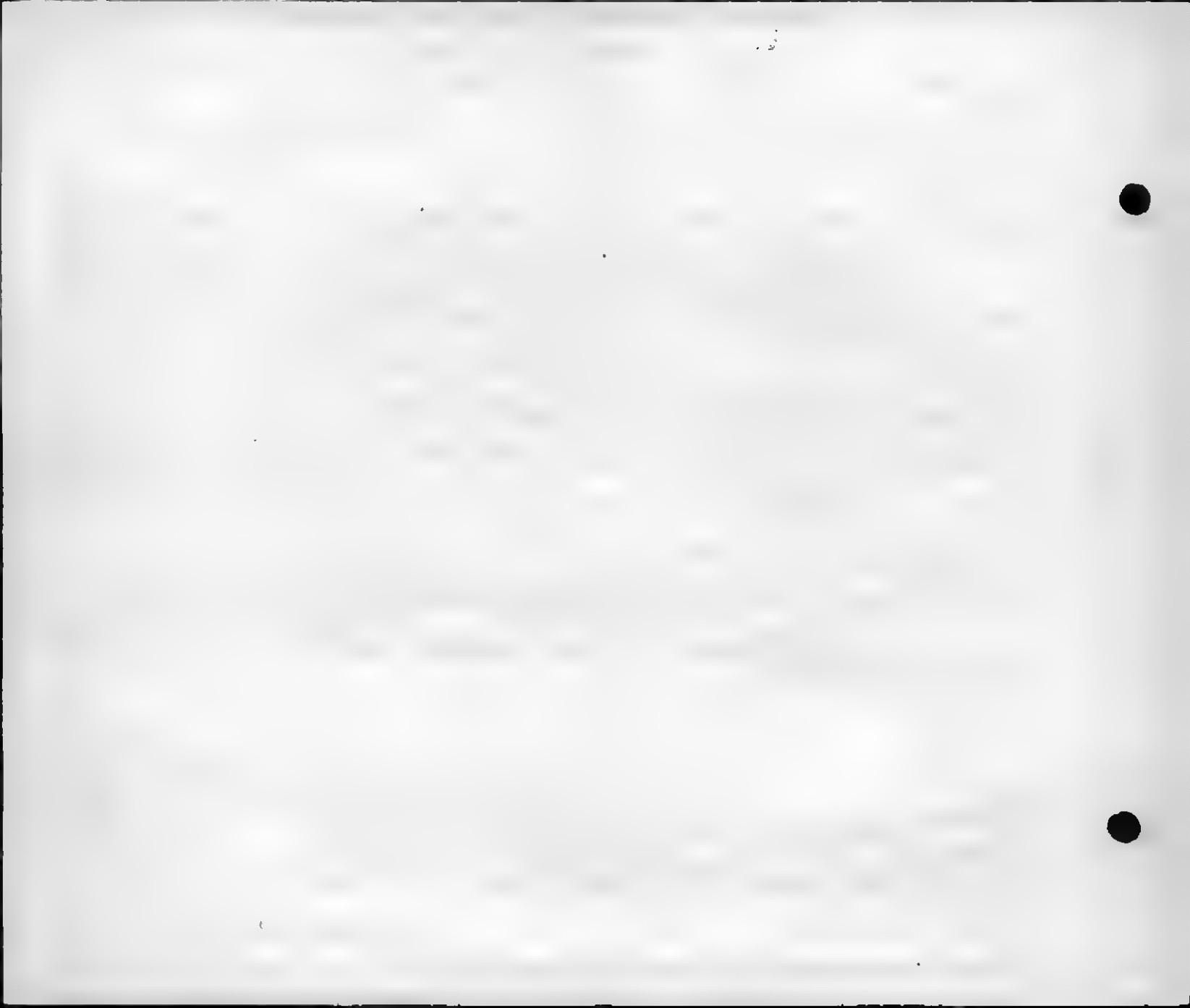
Reg. Dist. No.

101394

1. PLACE OF DEATH a. COUNTY <b>Baltimore Maryland</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>	c. LENGTH OF STAY IN lb <b>2 Years</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Caton Ridge Nursing Home 329 Harlem Lane - 28</b>		d. STREET ADDRESS <b>160 N. Gay St</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert</b>	First <b>S.</b>	Middle <b>Stanton</b>	4. DATE OF DEATH Month <b>Jan</b> Day <b>6</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 10, 1870</b>	9. AGE (In years last birthday yrs. <b>89</b> )	IF UNDER 1 YEAR Months <b>11</b>	IF UNDER 24 HRS. Days <b>27</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Stephen Stanton</b>		14. MOTHER'S MAIDEN NAME <b>Martha Stinegant</b>		Address <b>329 Harlem La Caton Ridge Nursing Home, Catonsville, Md</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Artherosclerosis (Acute Coronary Insufficiency)</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>Emphysema -</b> DUE TO (b) (c) INTERVAL BETWEEN ONSET AND DEATH immediate unknown						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)	
21. I certify that I attended the deceased from <b>Jan 15, 1958, to Jan 16, 1960</b> , that I last saw the deceased alive on <b>1/4 1960</b> , and that death occurred at <b>5 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4605 Edmondson Ave</b> DATE SIGNED <b>1/6/60</b>						
ACTUAL SIGNATURE <b>Cliff Ratliff, M.D.</b>						
PHYSICIAN'S NAME (Type) <b>CLIFF RATLIFF, JR. BALTIMORE 29, MD.</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	22b. DATE THEREOF <b>1-6-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Greenmount Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>David R. Martin</b>		ADDRESS <b>1902 Eutaw Place</b>	24a. REC'D BY REGISTRAR DATE <b>JAN 11 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Khan</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



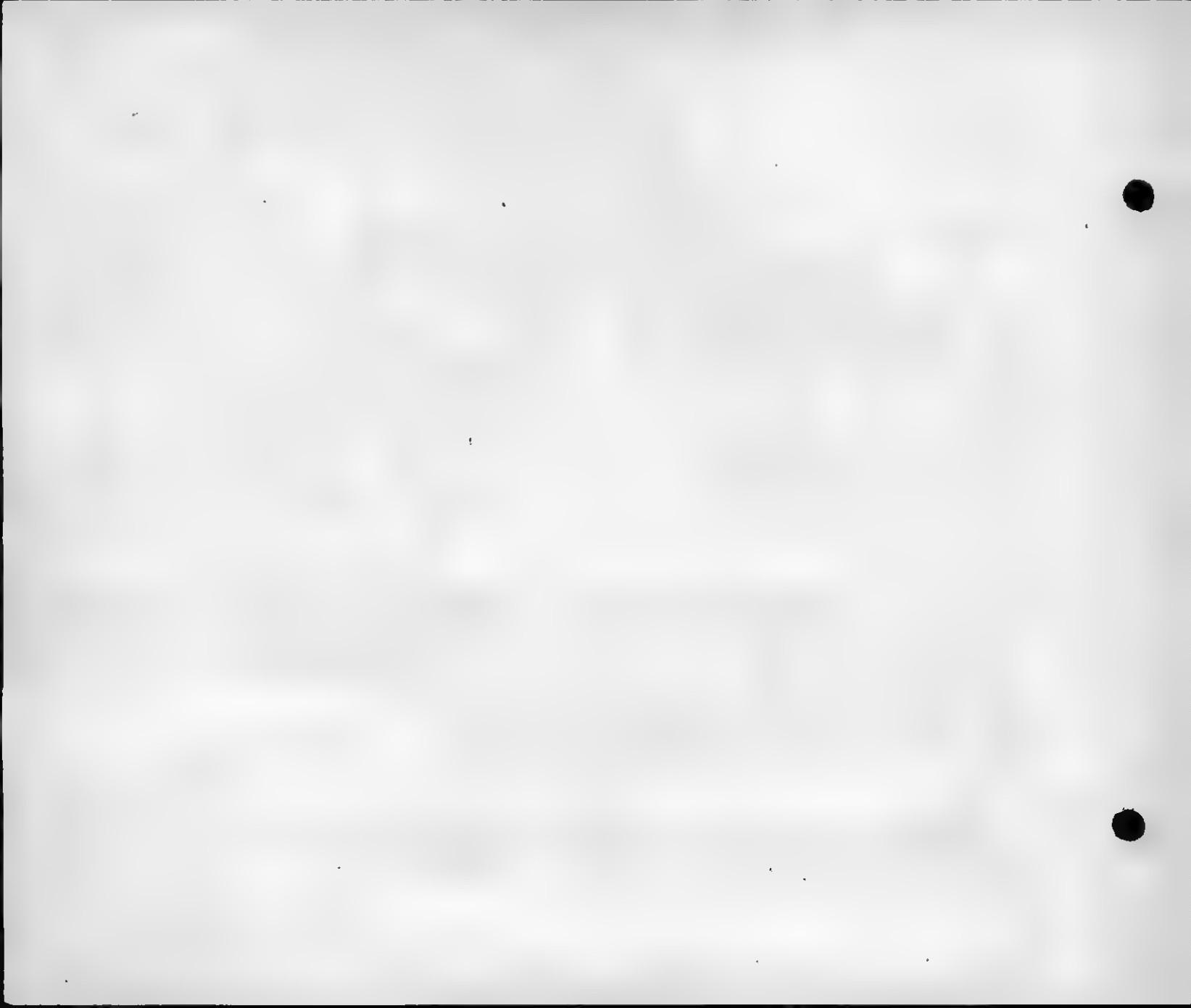
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **00395**

1. PLACE OF DEATH a. COUNTY <b>Balt. 0400</b>  b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Wilson, Md.</b>  c. LENGTH OF STAY IN 1b <b>19 mts</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>  b. COUNTY <b>Balt.</b>  c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Balt. 21</b>  d. STREET ADDRESS <b>K 44 Eastern Ave. Balt.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>EARL H.</b>		First	Middle <b>STEED</b>	Last	4. DATE OF DEATH <b>Jan 12 1960</b>	Month	Day	Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-22-1911</b>	9. AGE (in years to birthday) <b>48 yrs.</b>	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Railroad Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rail Road.</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Steed</b>		14. MOTHER'S MAIDEN NAME <b>Emma Miner</b>		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>280-10-4507</b>		17. INFORMANT <b>Mt. Wilson Prop. Records - Mt. Wilson, Md.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO (c)		Coronary artery disease						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Bilateral Pulmonary Thc. 12 yrs.</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <b>No.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <b>Bumper st. eye brow when he expired.</b>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>6:30</b> p.m. <b>1-12 1960</b>		20d. INJURY OCCURRED While <b>Not while</b> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Curbwalk.</b>		20f. (City or town) <b>Mt. Wilson</b> (County) <b>Balt.</b> (State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>D.D. Caples</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1-12-60</b>		
EXAMINER'S NAME (Type) <b>D.D. CAPLES</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>1-14-60</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>VALLEY</b>		22d. LOCATION (City, town, or county) <b>MARIETTA - OHIO</b>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joy G. Connally</b>		ADDRESS <b>Box 21 - Md.</b>		24a. REC'D BY REGISTRAR <b>Arthur L. Krause</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Krause</b>		
				DATE JAN 18 '60				

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

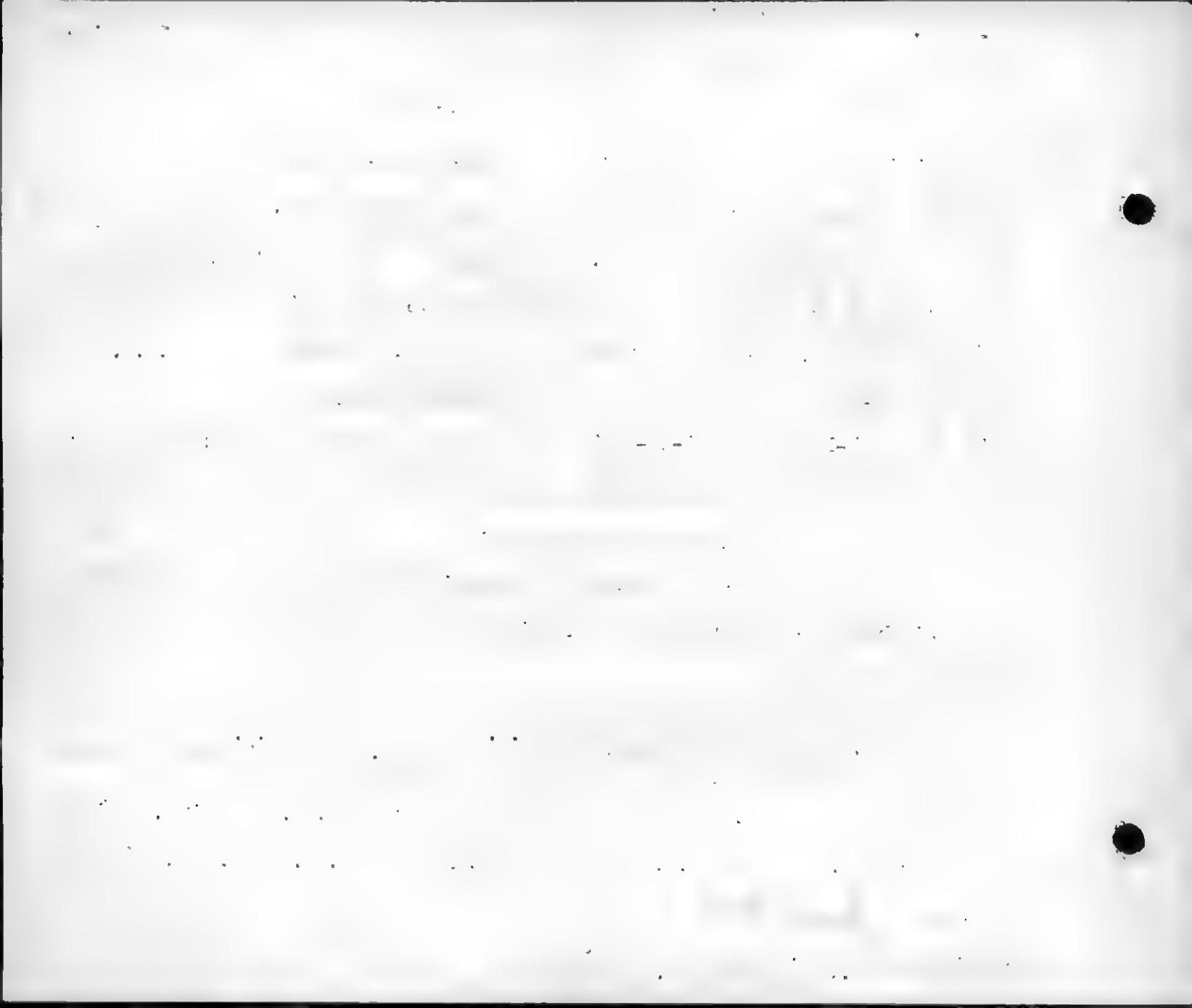
## CERTIFICATE OF DEATH

Reg. Dist. No.

00396

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relied on by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

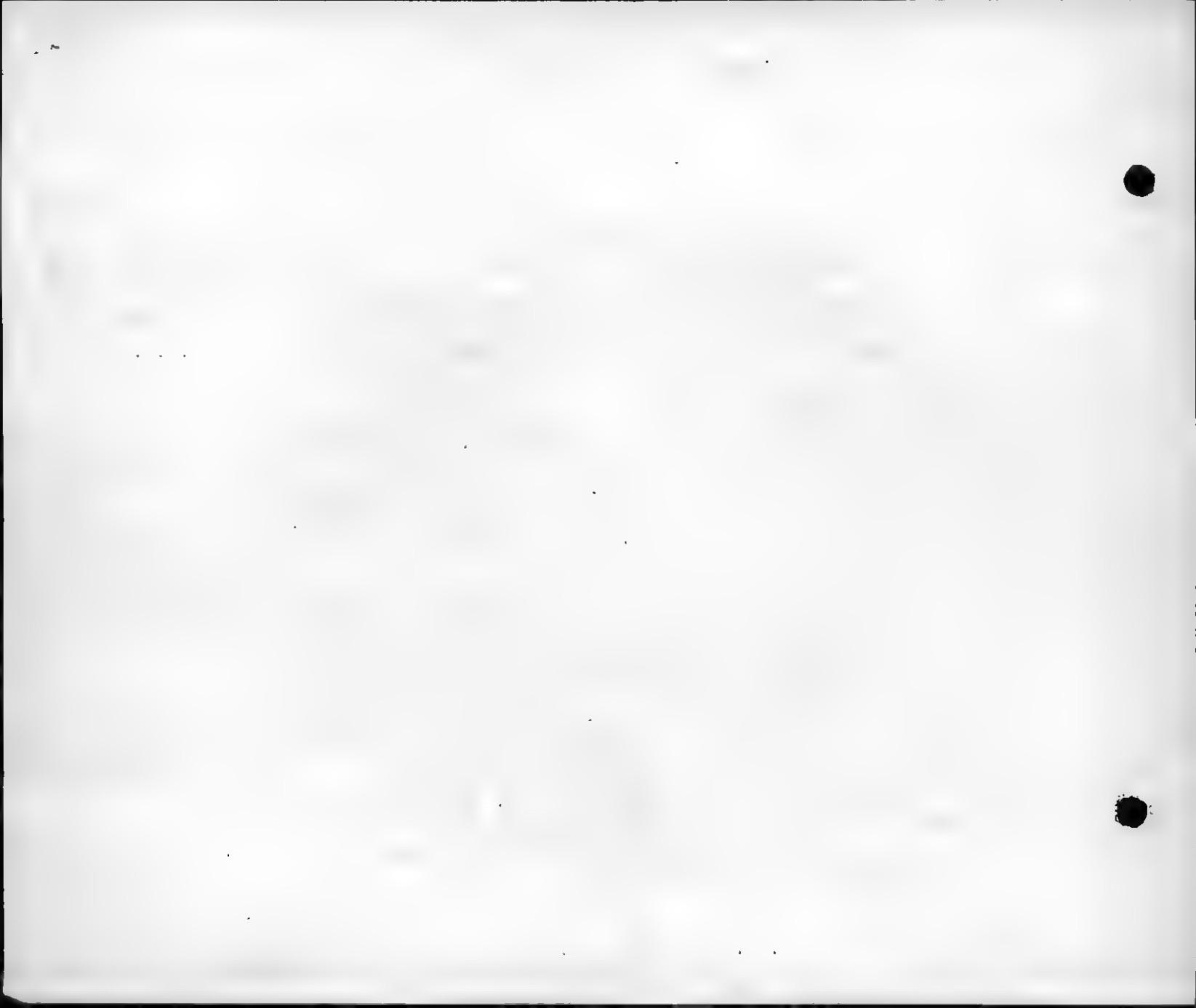
1. PLACE OF DEATH o COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		c. LENGTH OF STAY IN 1b <b>21 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>VETERANS ADMINISTRATION HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>CHRISTOPHER</b>	Middle <b>W.</b>	Last <b>STEEG</b>
4. DATE OF DEATH	Month <b>JANUARY</b>	Day <b>10</b>	Year <b>1960</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 23, 1892</b>
9. AGE (In years last birthday) <b>67</b> yrs		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>BARTENDER, BEYER'S CAFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BALTIMORE, MARYLAND</b>	
10c. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LOUIS STEEG</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH WAGNER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>213-20-6212</b>	
17. INFORMANT <b>CLIN REC VAH BALTO MD FT HOWARD DIVISION</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE EDEMA OF LUNGS</b>			
DUE TO <b>454.4</b>			
INTERVAL BETWEEN ONSET AND DEATH HOURS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>CARDIAC DECOMPENSATION</b>			
DUE TO <b>1 DAY</b>			
(c) <b>HYPERTROPHY AND DILATATION OF HEART</b>			
DUE TO <b>UNKNOWN</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>Chronic bleeding peptic ulcer of stomach</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>4:25 P.M.</b>		20f. (City or town) (County) (State) <b>1:25 P.M.</b>	
21. I certify that <b>VA</b> attended the deceased from <b>Jan. 9, 1960</b> , to <b>Jan. 10, 1960</b> , and that death occurred at <b>1:25 pm</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John W. Crawford</i>		ADDRESS (Street, city or town, state) <b>VAH, BALTO 18, MD. FT. HOWARD DIV.</b>	
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b>		DATE SIGNED <b>1/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>January 12, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>MT. CARMEL CEMETERY</b>		22d. LOCATION (City, town, or county) <b>BALTIMORE MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Clarence Hoffman Funeral Home</b>		ADDRESS <b>C. F. Hoffmann</b>	
VS ATS (4) 15M 9/58		24a. REC'D BY REGISTRAR DATE <b>JAN 12 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Krasa</b>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Item 14 Film G254 1-8-60 et CERTIFICATE OF DEATH												Reg. Dist. No. <i>(011397)</i>									
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <b>MARYLAND</b>																	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>				c. LENGTH OF STAY IN 1b <b>40 years</b>				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>													
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>16 Kinship Road</b>				e. STREET ADDRESS <b>16 Kinship Road</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First <b>ELIZABETH</b>		Middle		Last <b>STONE</b>		4. DATE OF DEATH <b>January 1,</b>		Month	Day	Year									
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 2, 1909</b>		9. AGE (In years last birthday) <b>50 yrs</b>		IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At home</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Penna.</b>				12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Francis J. Mehoke</b>						14. MOTHER'S MAIDEN NAME <b>Mary Broda</b>						Address									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>			16. SOCIAL SECURITY NO			INFORMANT <b>Dorror P. Stone 16 Kinship Road</b>			INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>												
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>170X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO DUE TO DUE TO																					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CARCINOMA of Rt BREAST c metastasis (General) -</b>												INTERVAL BETWEEN ONSET AND DEATH <b>18 mos.</b>									
MEDICAL CERTIFICATION	20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>OK</b>				20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) <b>Colgate, Md.</b>		(County)		(State)		
	21. I certify that I attended the deceased from <b>Dec. 30</b> , 1958, to <b>JAN. 1</b> , 1960, that I last saw the deceased alive on <b>Dec. 30</b> , 1959, and that death occurred on <b>10 P.M.</b> from the causes and on the date stated above.													ADDRESS (Street, city or town, state) <b>6800 Maryland Ave.</b>				DATE SIGNED <b>1/3/60.</b>			
	ACTUAL SIGNATURE <b>M. B. Davis M.D.</b>																				
PHYSICIAN'S NAME (Type) <b>M. B. Davis M.D.</b>																					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/4/60</b>				22c. NAME OF CEMETERY OR CREMATORIUM <b>Oak Lawn Cemetery</b>				22d. LOCATION (City, town, or county) <b>Colgate, Md.</b>				(State)								
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ulrich Funeral Home. 2112 Dundalk Ave.</b>	ADDRESS				24a. REC'D BY REGISTRAR <b>JAN 5 '60</b>				24b. REGISTRAR'S SIGNATURE <b>Collegia S. Kline</b>												
VS A15 (4) 15M 9/58																					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0235

## CERTIFICATE OF DEATH

Reg. Dist. No.

00398

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cella</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cella</b>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First <b>ANNIE</b>	Middle <b>C</b>	Last <b>STONESIFER</b>	4. DATE OF DEATH <b>Jan. 3, 1960</b>	Month	Day	Year
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5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>9-12-1867</b>	9. AGE (In years last birthday) <b>92</b> yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours	13. Min.
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY?
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13. FATHER'S NAME ?	14. MOTHER'S MAIDEN NAME ?
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO.	INFORMANT	Address
		<b>John Stonesifer, Cella Ave., Cella, Md</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiac vascular disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>5 year</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)
--

Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
---	--	--	--	--	--

20c. TIME OF INJURY Month, Day, Year Hour p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
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21. I certify that I attended the deceased from <b>11-24</b> to <b>1-3</b> , 19 <b>53</b> , that I last saw the deceased alive on <b>12-29</b> , 19 <b>53</b> , and that death occurred at <b>6:30 p.m.</b> M, from the causes and on the date stated above.
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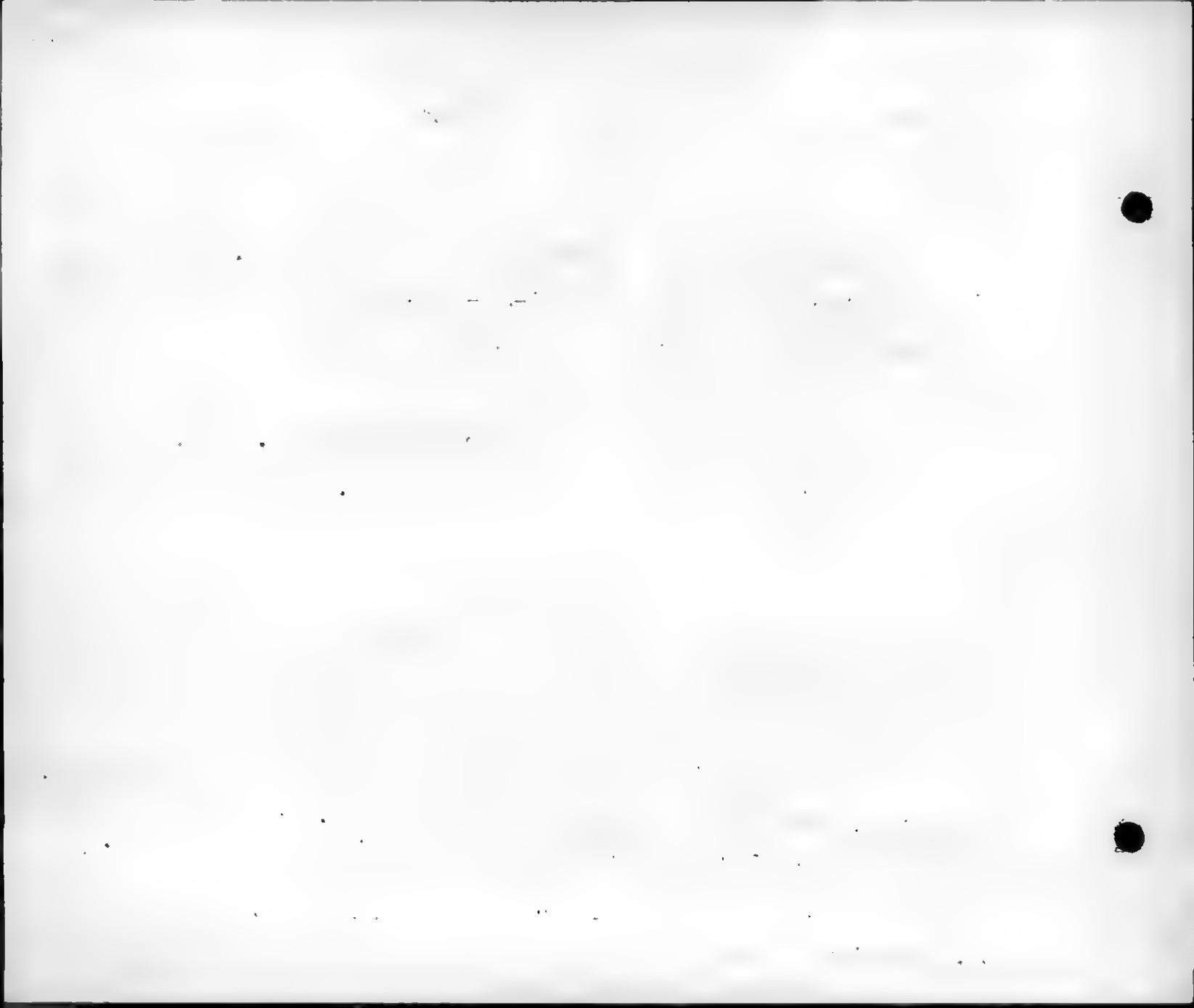
ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL SIGNATURE <i>Thomas F. Herbert, M.D.</i>	PHYSICIAN'S NAME (Type) <i>Thomas F. Herbert, M.D.</i>	46 Church Road Ellicott City, Md 1-460
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22a. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Good Shepherd</b>	22d. LOCATION (City, town, or county) <b>Ellicott City, Md</b>	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE <b>F.C. Higinbotham, Ellicott City, Md</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>	24b. REGISTRAR'S SIGNATURE <i>Office 8 AM</i>
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0408

## CERTIFICATE OF DEATH

Reg. Dist. No.

00393

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be relied upon by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
1 PLACE OF DEATH Rosewood State Training School

o. COUNTY

Baltimore

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Crings Mills, Maryland

c. LENGTH OF STAY IN lb

12 yrs.

d. NAME OF HOSPITAL (If not in hospital, give street address)  
OR INSTITUTION

Rosewood State Training School

3. NAME OF  
DECEASED  
(Type or print)First  
JuliaMiddle  
GertrudeLast  
Storm4. DATE  
OF  
DEATHMonth  
1Day  
18Year  
1960

5. SEX

Female

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

2/5/45

9. AGE (In years  
last birthday)

14

yrs.

10. USUAL OCCUPATION (Give kind of work done  
during most of working life, even if retired)

11. KIND OF BUSINESS OR INDUSTRY

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

10b. BIRTHPLACE (State or foreign country)

Maryland

13. FATHER'S NAME

Harrison Franklin Storm

14. MOTHER'S MAIDEN NAME

Myrtle Cassie Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown)16. SOCIAL SECURITY NO  
(If yes, give war or dates of service)

INFORMANT

Address

no

Rosewood Records

INTERVAL BETWEEN  
ONSET AND DEATH

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

581.0

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

Posthepatotic cirrhosis, extensive  
and marked anemiaINTERVAL BETWEEN  
ONSET AND DEATH

MEDICAL CERTIFICATION

20a ACCIDENT WAS UNDERLYING OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20c TIME OF INJURY Month, Day, Year  
Hour o. m. p. m. 1920d. INJURY OCCURRED  
While Not while  
of work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from \_\_\_\_\_, 19\_\_\_\_\_, to \_\_\_\_\_, 19\_\_\_\_\_, that I last saw the deceased  
alive on \_\_\_\_\_, 19\_\_\_\_\_, and that death occurred at 5:00 AM, from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

Peter W. Rieckert 4307 Mainfield Ave 1-19-60

PHYSICIAN'S  
NAME (Type)

Peter W. Rieckert

Baltimore 14, Md

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

22b. DATE THEREOF

Jan. 21, 60

22c. NAME OF CEMETERY OR CREMATORY

Carroll Chapel

22d. LOCATION (City, town, or county)

Balto. Co. Md

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

J.F. Eline &amp; Sons Reisterstown, Md.

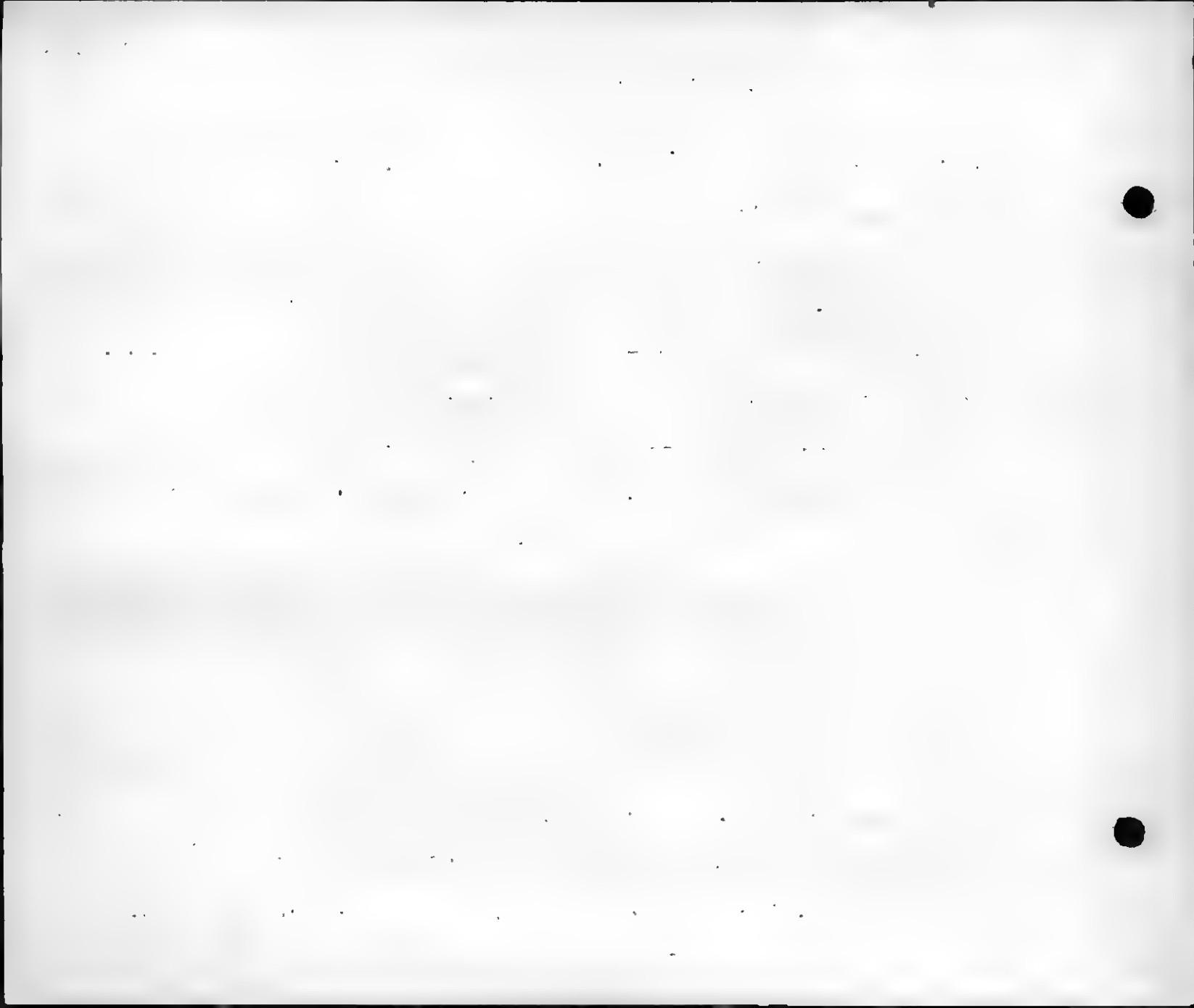
ADDRESS

24a. REC'D BY REGISTRAR

DATE JAN 21 '60

24b. REGISTRAR'S SIGNATURE

O. P. L. &amp; K. M.



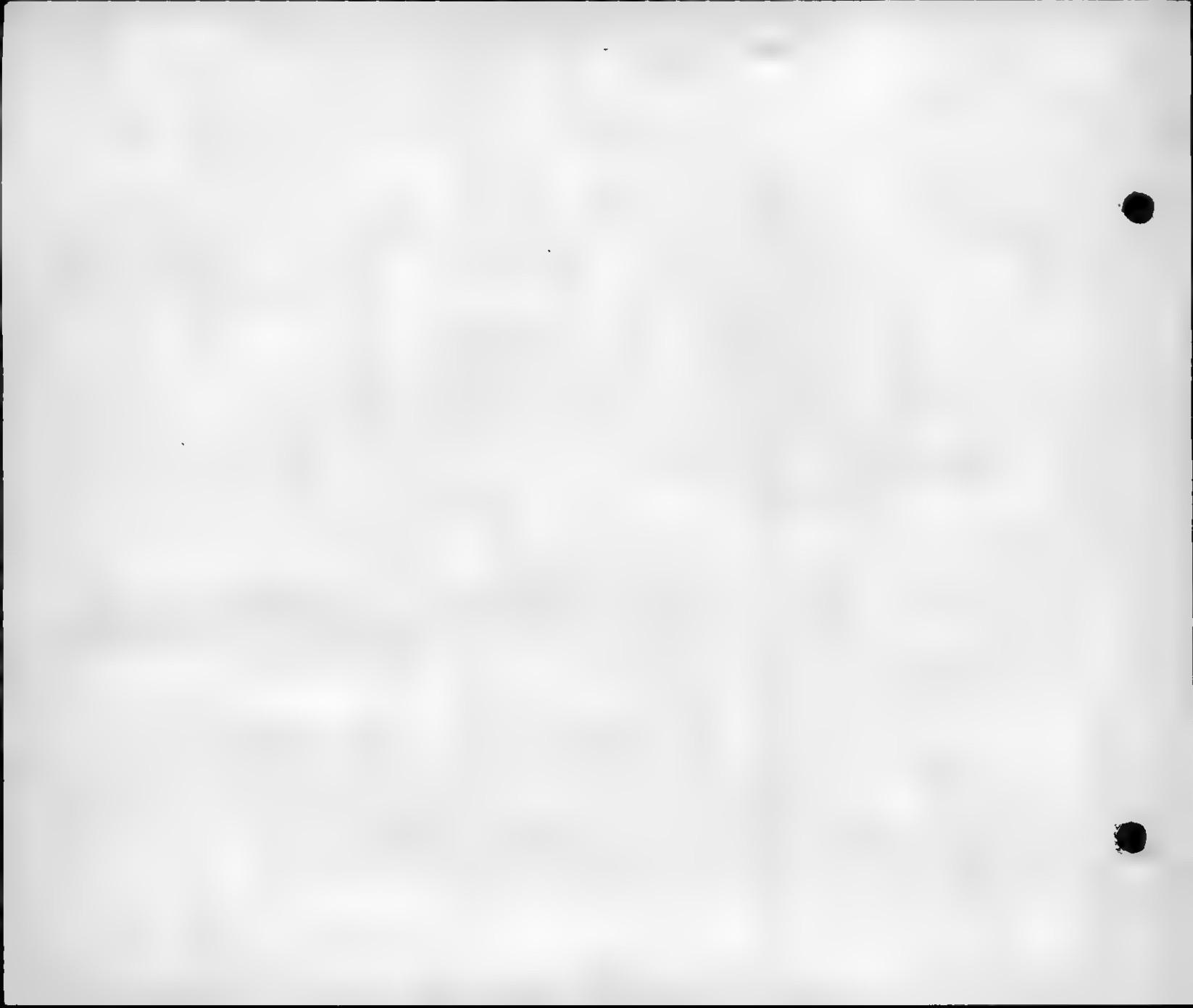
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00460

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		8226		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		
BALTO.		MARYLAND		a. STATE	MD.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		b. COUNTY		
DUNDALK		4 yrs.		BALTO.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
801 JAYDEE AVE.		DUNDALK				
f. STREET ADDRESS		g. DATE OF DEATH		h. IS RESIDENCE ON A FARM?		
801 JAYDEE AVE.		Month	Day	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	Year	
DORA		—	—	STREJCEK	1 21 1960	
4. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	
FEM.		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DEC. 7, 1877	82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		
HOUSEWIFE, AT HOME				MD.		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?		
NOT KNOWN		NOT KNOWN		USA		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		
NO		NONE		Mrs. CAROLINE JENDERCAK Address 801 JAY-		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED?				
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH				
443X DUE TO		Maj. Cardiac Degeneration 5 yrs				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first.		(b) Generalized Arteriosclerosis 20 yrs				
DUE TO		(c) Hyper Tension 20 yrs				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED?				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
19						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .						
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED
EXAMINER'S NAME (Type)		Jack C Collins				1-22-60
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State)
BURIAL		1125/60		LOUDON PARK		BALTO. MD.
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE
Geo. W. Hoffmann 3218 Hudson St.				JAN 25 '60		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director or, if Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00491

## CERTIFICATE OF DEATH

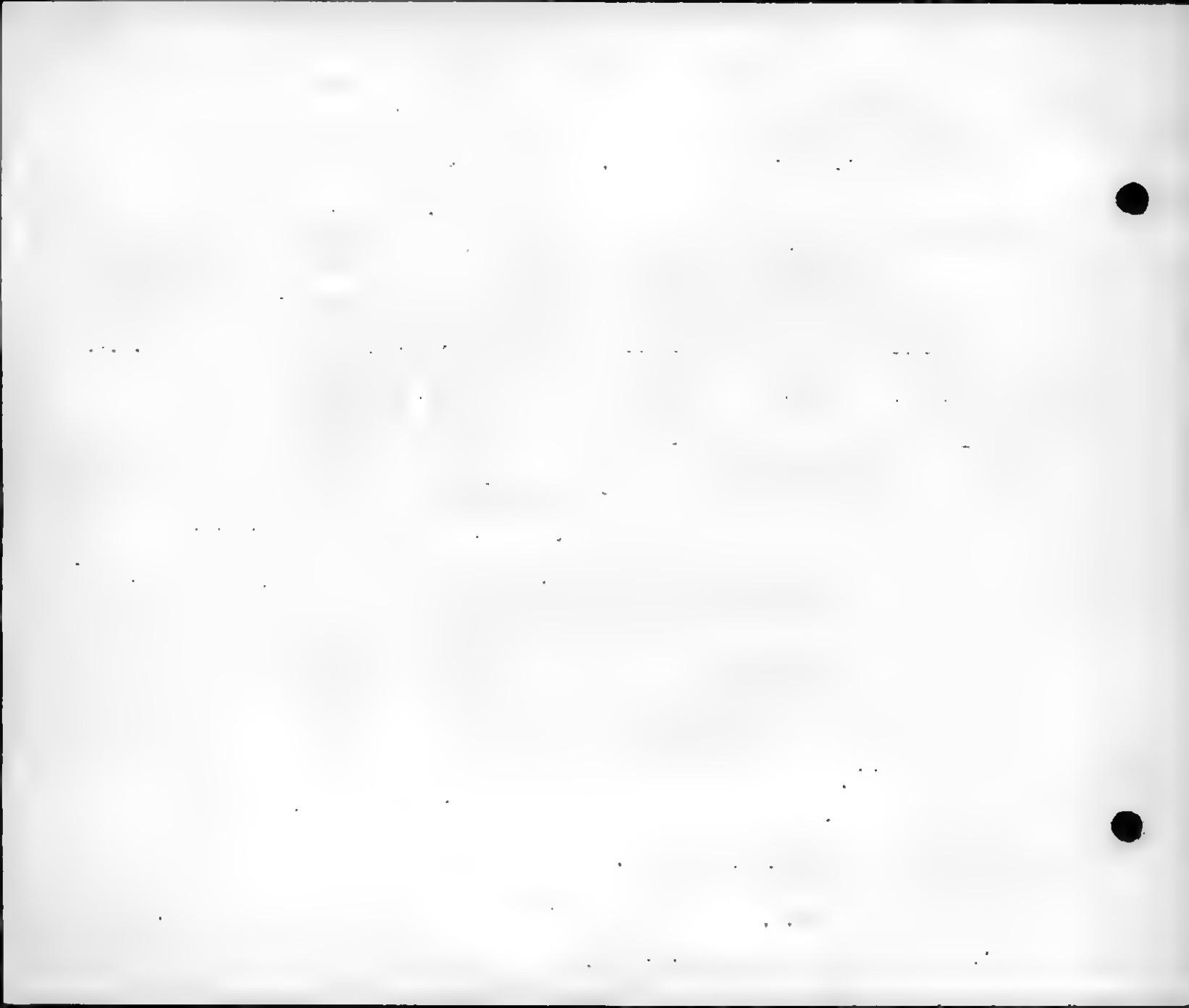
Reg. Dist. No.

040

1. PLACE OF DEATH a. COUNTY Baltimore		Rosewood State Training School MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland		b. COUNTY City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills, Maryland		c. LENGTH OF STAY IN lb 2½ mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland		d. STREET ADDRESS 821 W. Lexington Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Willie	Middle Stubbs	Last	4. DATE OF DEATH	Month 1	Day 31	Year 19 60
S. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 7-6-58	9. AGE (In years last birthday) 1 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Oscar Lee Stubbs				14. MOTHER'S MAIDEN NAME Eliza Jane Branson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO.		INFORMANT		Address Rosewood Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Naso-Pharyngitis with Inanition INTERVAL BETWEEN ONSET AND DEATH 1 day							
DUE TO (b) Hydrocephalus - due to Meningococcus Meningitis							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) with complicating Hydrocephalus & Spastic Quadriplegia since birth							
DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACC. DENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/19, 1959, to 1/31, 1960, that I last saw the deceased alive on 1/31, 1960, and that death occurred at 12:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Harry G. Butler, M.D. ADDRESS (Street, city or town, state) DATE SIGNED Owings Mills, Md. 3/1/60							
PHYSICIAN'S NAME (Type)		Harry G. Butler, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 4, 60		22c. NAME OF CEMETERY OR CREMATORIUM Rosewood Cemetery		22d. LOCATION (City, town, or county) (State) Owings Mills, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons Reisterstown, Md.				ADDRESS		24a. REGISTRY REGISTRAR FEB 5 1960	24b. REGISTRAR'S SIGNATURE C. J. Eline, Jr.
						DATE	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your information or removal.

VS. A15ME(5)  
5M 9/55

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08492

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>	c. LENGTH OF STAY IN 1b <b>13 yrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>White Hall</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Viola Sutton</b>		First	Middle
		Last	
4. DATE OF DEATH <b>Jan. 1</b>		Month	Day
		Year <b>1960</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 5, 1904</b>
		9. AGE (In years last birthday) <b>55</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	11. BIRTHPLACE (State or foreign country) <b>Freeland, Md., U.S.A.</b>
13. FATHER'S NAME <b>William Smith</b>		14. MOTHER'S MAIDEN NAME <b>Edith Hoshall</b>	12. CITIZEN OF WHAT COUNTRY? <b>C. S.A.</b>
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>[Signature]</b>	17. INFORMANT <b>J. Webster Sutton, White Hall, Md.</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b>			
Conditions, if any, which go rise to immediate cause (a), stating the underlying cause last. <b>Coronary occlusion</b>		DUE TO <b>Instant</b>	
(b) <b>Coronary occlusion</b>		DUE TO <b>Instant</b>	
(c) <b>Coronary occlusion</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Free Land Rd.</b>
		20f. (City or town) <b>Free Land Rd.</b>	(County) <b>Freeland</b>
		(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>A. M. France</b>		DATE SIGNED <b>Jan. 2, 1960</b>	
EXAMINER'S NAME (Type) <b>A. M. France</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 4, 1960</b>	
		22c. NAME OF CEMETERY OR CREMATORIUM <b>Middletown Cemetery</b>	
		22d. LOCATION (City, town, or county) <b>Free Land Rd.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul Hartenstein, New Freedom, Pa.</b>		24a. REC'D BY REGISTRAR <b>Arthur S. Kraus</b>	
		ADDRESS <b>100 Main Street, New Freedom, Pa.</b>	
		DATE <b>JAN 6 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
0227 CERTIFICATE OF DEATH

00403

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>		c. LENGTH OF STAY IN 1b <b>66 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2 FRIENDSHIP CIRCLE</b>		e. C.TY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DUNDALK</b>	
d. STREET ADDRESS <b>2 FRIENDSHIP CIRCLE</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>JOHN</b>	Middle <b>A.</b>	Last <b>TANTTARI</b>
4. DATE OF DEATH	Month <b>JAN</b>	Year <b>'60</b>	Day <b>7</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>DEC 31 1884</b>
9. AGE (In years & last birthday) <b>75 yrs.</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>METALLURGIST</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>STEEL</b>	11. BIRTHPLACE (State or foreign country) <b>FINLAND</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	13. FATHER'S NAME <b>MATTI TANTTARI</b>		
14. MOTHER'S MAIDEN NAME <b>SALLY TANTTARI - 2 FRIENDSHIP CIRCLE</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		
16. SOCIAL SECURITY NO. <b>INFORMANT</b>	17. INTERVAL BETWEEN ONSET AND DEATH <b>6 years</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Hemorrhage</b> <b>arteriosclerosis &amp; Hypertension</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>July 16, 1958</b> , to <b>Jan 7, 1960</b> what I last saw the deceased alive on <b>Jan 7, 1960</b> , and that death occurred at <b>10 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Eugene F Neary MD 7001 Mooring Glen Rd Dundalk MD</b>			
ACTUAL SIGNATURE <b>Eugene F Neary</b>	DATE SIGNED <b>1-8-60</b>		
PHYSICIAN'S NAME (Type) <b>Eugene F Neary</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/11/60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>ONE LAWN</b>	22d. LOCATION (City, town, or county) <b>OOLICATE MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>ULLRICH FUNERAL HOME - DUNDALK MD</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 12 '60	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be ret'd by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0411 CERTIFICATE OF DEATH

00404

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>BALTO.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN b <b>1010 FREDERICK RD.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1010 FREDERICK RD.</b>		e. STREET ADDRESS <b>1010 FREDERICK RD.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ANNIE GERTRUDE TAUBER</b>		First	Middle
4. DATE OF DEATH <b>JAN. 31 1960</b>	Last	Month	Day
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 29, 1884</b>
9. AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR Months <b>—</b>	11. IF UNDER 24 HRS Days <b>—</b>	12. Year <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEKEEPER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
10c. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JAMES CROOK</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN QUINN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>John H. Tauber - 1010 Frederick Rd.</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>442 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Cardio Vascular Disease 4 yrs</b> <b>Atherosclerosis 5 yrs.</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sensibility</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      Month      Day      Year p. m.      19		20d. INJURY OCCURRED While not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>		20f. (City or town) (County) (State) <b>—</b>	
21. I certify that I attended the deceased from <b>Jan 15 1960</b> to <b>Jan 31 1960</b> , that I last saw the deceased alive on <b>Jan 15 1960</b> , and that death occurred at <b>11 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>4209 Fred Ave</b>			
ACTUAL SIGNATURE <b>A.H. Crowther</b>		DATE SIGNED <b>2/1/60</b>	
PHYSICIAN'S NAME (Type) <b>A.H. CROWTHER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-3-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Cathedral Cem.</b>		22d. LOCATION (City, town, or county) <b>Balto</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Sibley Funeral Home - Catonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 5 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 filing 2525 2-60 et  
0412 CERTIFICATE OF DEATH

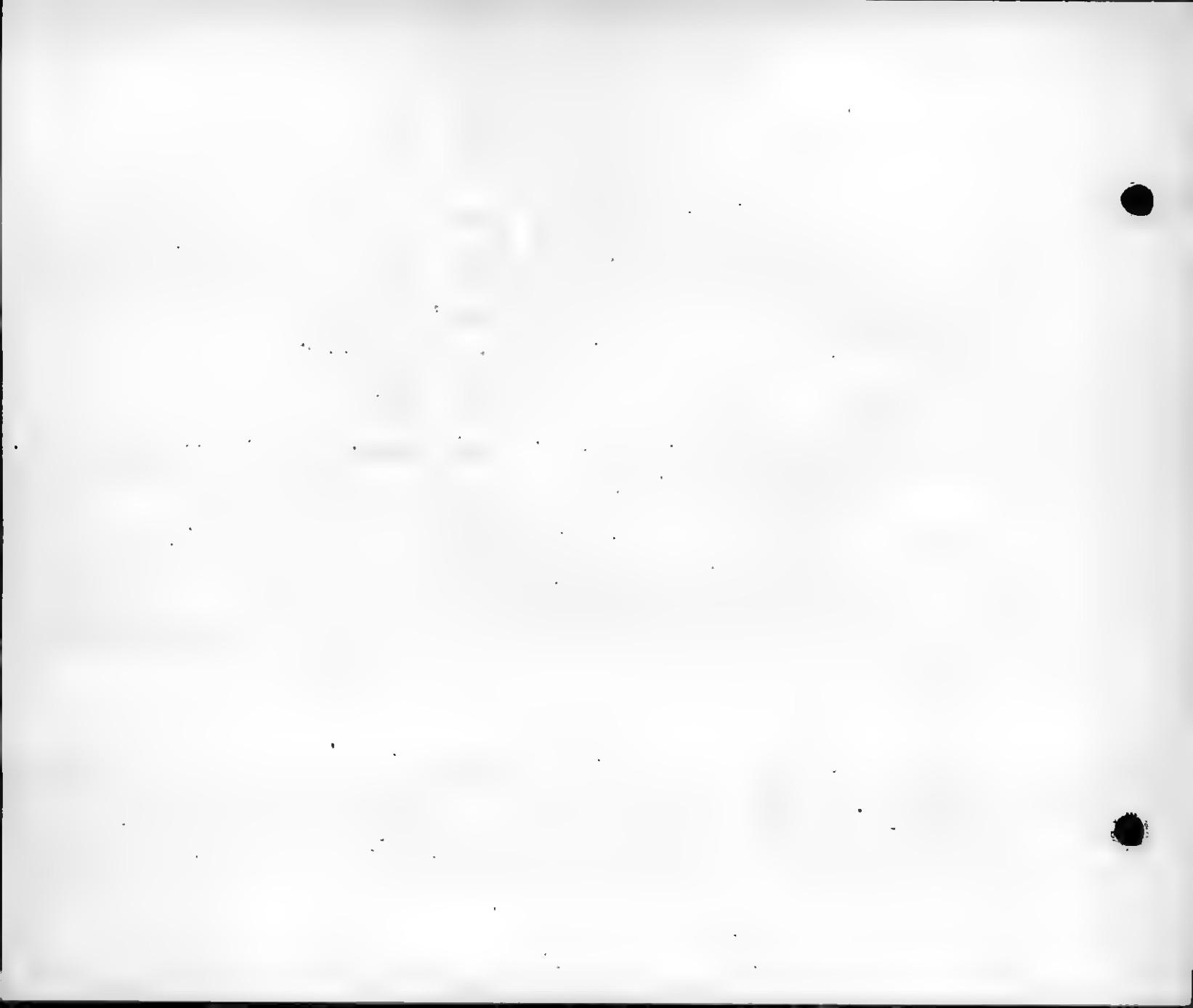
Reg. Dist. No.

00405

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PLACE OF DEATH a. COUNTY  Baltimore		MARYLAND		2. USUAL RESIDENCE [Where deceased lived, if institution; Residence before admission] a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  X Baltimore			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  2604 Poplar Drive				d. STREET ADDRESS  2604 Poplar Drive #7		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CHARLES	Middle H.	Last TAYLOR	4. DATE OF DEATH	Month January 27	Day 19	Year 60
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	b. DATE OF BIRTH March 17, 1878	9. AGE (In years lost birthday) 81 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chairman of Board - Home Mutual Life Ins. Co.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Axbridge, England		12. CITIZEN OF WHAT COUNTRY? Unknown	
13. FATHER'S NAME Henry Taylor				14. MOTHER'S MAIDEN NAME Kitty Walker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 215-01-0651		INFORMANT Mrs. Elizabeth E. Bauer-3137 Chesterfield Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> INTERVAL BETWEEN ONSET AND DEATH 5 days  442 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Hypertension Arterosclerotic C-V-D, Nephrosclerosis</i> , years DUE TO Due to (c) <i>Cerebral Scarring Atherosclerosis</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  None							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)  None		20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		ADDRESS (Street, city or town, state)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from 12-29, 1956, to 1-20, 1960, that I last saw the deceased alive on 1-20, 1960, and that death occurred at 6P M, from the causes and on the date stated above.  ACTUAL SIGNATURE <i>John Asbury</i> M.D. <i>5901 Langm Oak Dr</i> PHYSICIAN'S NAME (Type) <i>Balto, Md.</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/30/60		22c. NAME OF CEMETERY OR CREMATORIUM Loudon Park Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Wm J. Tickner</i>		ADDRESS <i>Balto, Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 29 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0241

## CERTIFICATE OF DEATH

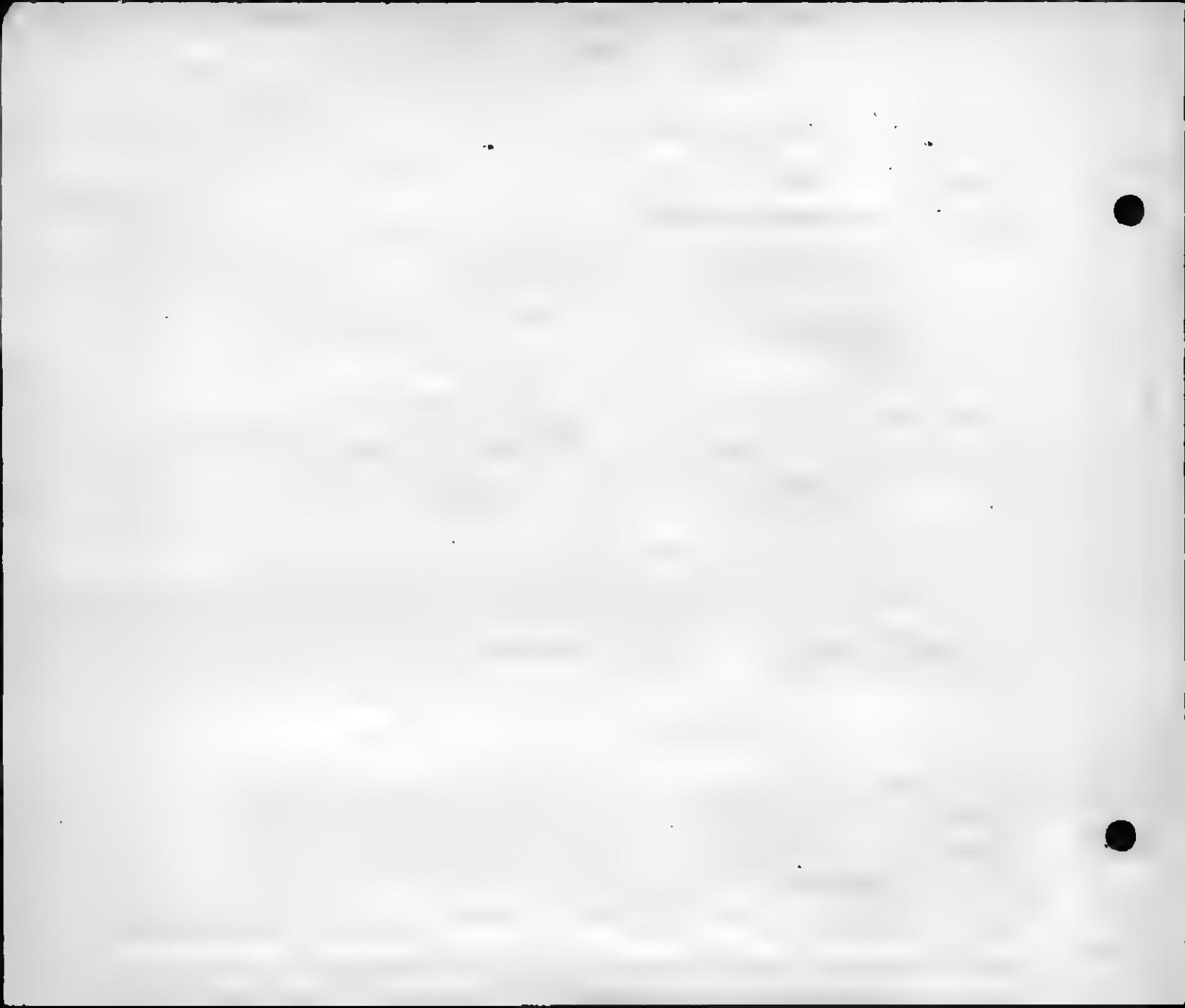
Reg. Dist. No.

00406

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Hanover</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>		b. COUNTY <i>Hanover</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>		c. LENGTH OF STAY IN 1b <i>8 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hanover</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>412 Shirley Manor Road</i>		d. STREET ADDRESS <i>412 Shirley Manor Rd</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First <i>Tobias</i>	Middle <i>lynn</i>	Last <i>Tobias</i>	4. DATE OF DEATH <i>June 11, 1966</i>	Month <i>June</i>	Day <i>11</i>	Year <i>1966</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>as</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 11, 1857</i>	9. AGE (in years last birthday) <i>69 yrs.</i>	10. IF UNDER 1 YEAR Months <i>6</i>	Days <i>27</i>	11. IF UNDER 24 HRS Hours <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>Baltimore - Hanover, Md</i>		
13. FATHER'S NAME <i>Filbert Tobias</i>		14. MOTHER'S MAIDEN NAME <i>Candice Miller</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>111-11-1111</i>		17. INFORMANT <i>Filbert Tobias - Hanover, Md</i>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>773.0</i>		DUE TO <i>liver disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>digestive failure</i>		DUE TO <i>liver disease</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i>		
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Manslaughter</i>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) <i>stabbed</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>home</i>		20f. (City or town) (County) (State) <i>Baltimore, Md</i>		
21. I certify that I attended the deceased from <i>6-11-1959</i> to <i>6-11-1966</i> , that I last saw the deceased alive on <i>June 18, 1966</i> , and that death occurred at <i>9 A.M.</i> from the causes and on the date stated above.								
ACTUAL SIGNATURE <i>Filbert Tobias - Hanover, Md</i>								
PHYSICIAN'S NAME (Type) <i>1930 Fulton Street, Baltimore, Md</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Jan 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Oaks-Bethel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Md</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Kavanagh</i>		ADDRESS <i>Salisbury Drive - 6010 Hunt Road</i>		24a. REC'D BY REGISTRAR <i>John J. Kavanagh</i>		24b. REGISTRAR'S SIGNATURE <i>John J. Kavanagh</i>		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Reg. Dist. No. 00497

1		0418			
1. PLACE OF DEATH a. COUNTY		Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		221 Preston Court		e. STREET ADDRESS 221 Preston Court	
3. NAME OF DECEASED (Type or print)		First George	Middle Wilson	Lost Todd	4. DATE OF DEATH Jan. 12, 1960
5. SEX		6. COLOR OR RACE M. W.	7. MARRIED NEVER MARRIED WIDOWED DIVORCED	8. DATE OF BIRTH May 22, 1890	9. AGE (In years last birthday) 69 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Retired Locomotive Engineer, B&O RR.		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME William J. Todd		14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Mary Todd, 221 Preston Crt. Catonsville	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]				Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		DUE TO H2O, 1		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (b)		DUE TO			
(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not white of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		<i>S. M. Kieffer</i> GEO. S. M. KIEFFER MD		DATE SIGNED <i>Jays 2 60</i>	
22a. BURIAL, CRIMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 15/60		22c. NAME OF CEMETERY OR CREMATORIUM Springhill Cemt.	
22d. LOCATION (City, town or county) Easton Md.				22e. REC'D BY REGISTRAR DATE JAN 15 '60	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Dir. 4101 Edmondson Ave.		ADDRESS		24e. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



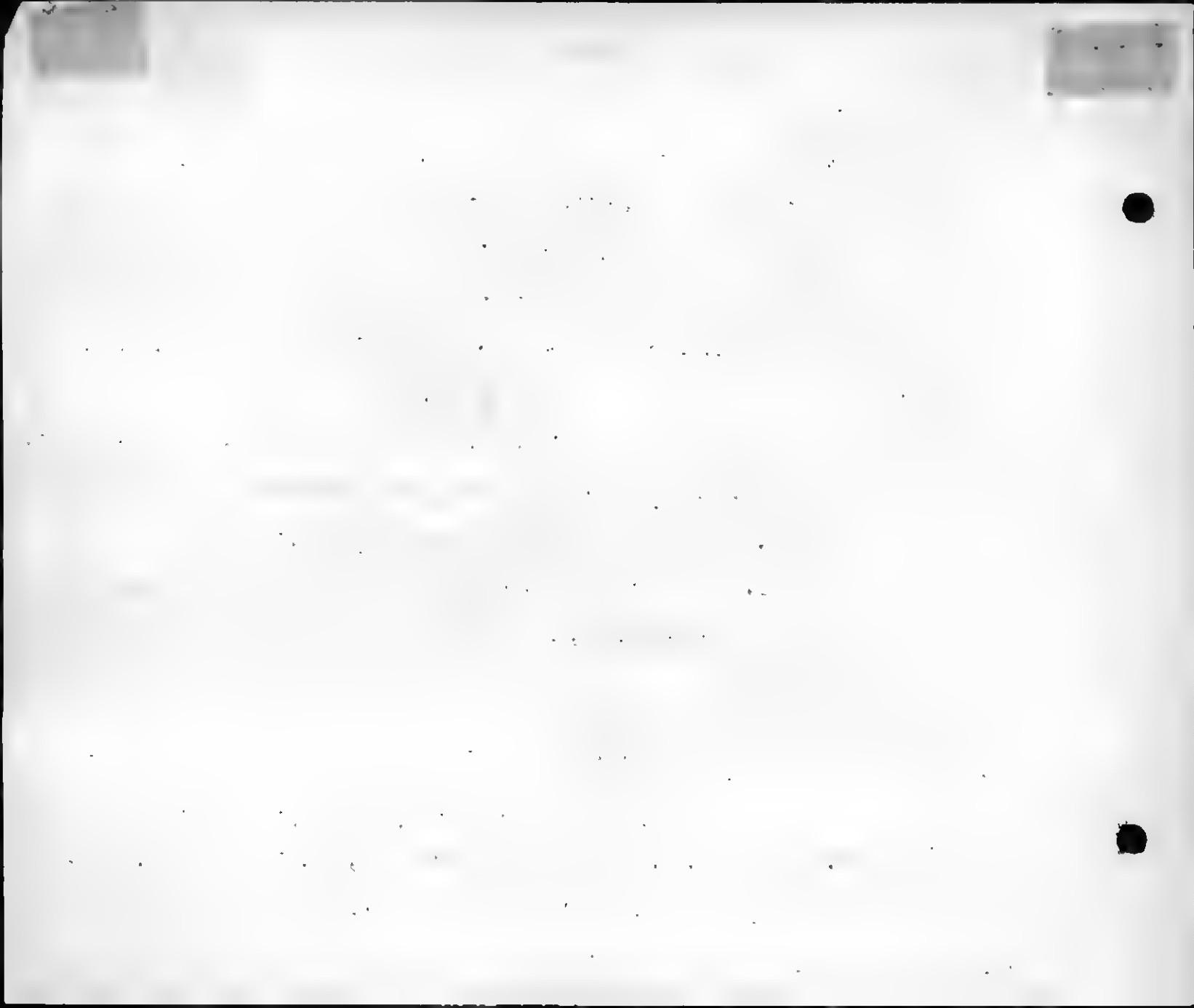
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0414 CERTIFICATE OF DEATH

Reg. Dist. No.

00408

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>33 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>LAWRENCE</b>	Middle <b>W.</b>	Last <b>TOOMEY</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>4</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1888</b>
9 AGE (In years last birthday) <b>71</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>	11. KIND OF BUSINESS OR INDUSTRY <b>U.S. Internal Rev.</b>	12. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
13. FATHER'S NAME <b>George Toomey</b>	14. MOTHER'S MAIDEN NAME <b>Mary E. Hoyer</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>	16. SOCIAL SECURITY NO. <b>WW I</b>	INFORMANT <b>Clin. Rec., VAH, Baltimore 18, Md. Fort Howard Div.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION WITH MURAL THROMBOSIS OF XBOOK OF THE LEFT VENTRICLE</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. { 2. <b>THROMBOSIS OF THE LEFT MAIN ILLIAC ARTERY WITH DRY GANGRENE OF LEFT LEG AND THIGH</b> 3. <b>BRONCHOPNEUMONIA, BILATERAL</b>			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHRONIC PYELONEPHRITIS, BILATERAL</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>		20f. (City or town) (County) (State) <b>VA</b>	
21. I certify that I attended the deceased from <b>Dec. 2, 1959</b> , to <b>January 4, 1960</b> , and that death occurred at <b>8:15 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>John D. Talbert, M.D.</i>		ADDRESS (Street, city or town, state) <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>	
DATE SIGNED <b>1/4/60</b>			
PHYSICIAN'S NAME (Type) <b>JOHN D. TALBERT, M. D.</b>		VAH, BALTO 18, MD. FT HOWARD DIV. 1/4/60	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-6-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto. 14, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE JAN 6 '60	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

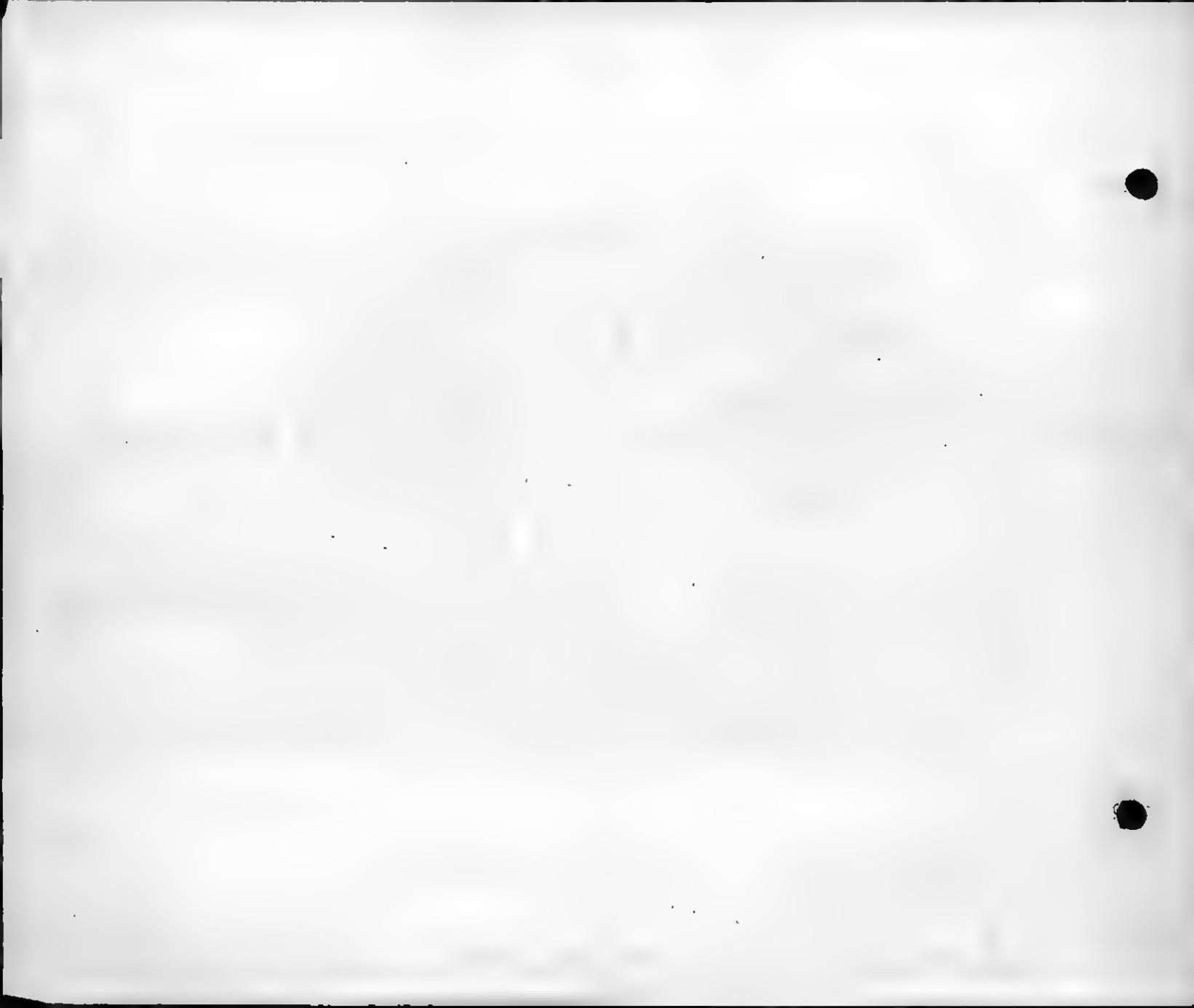
## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0403

## CERTIFICATE OF DEATH

Reg. Dist. No. 00499

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>	MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, Res dence before admission) a. STATE <i>Maryland</i>	b. COUNTY <i>Baltimore</i>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Dennis Rd.</i>	c. LENGTH OF STAY IN 1b <i>2 yrs</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>St. Dennis - P.D.</i>	d. STREET ADDRESS <i></i>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <i>JONATHAN-</i>	First <i></i>	Middle <i></i>	Last <i>TRACEY</i>	4. DATE OF DEATH Month <i>Jan</i>	Day <i>16</i>	Year <i>1960</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Feb 21-1866</i>	9. AGE (In years less birthday) <i>93 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS Days <i></i>	12. IF UNDER 24 HRS Hours <i></i>	13. IF UNDER 24 HRS Min <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Biscuitman</i>	11. BIRTHPLACE (State or foreign country) <i>Ned</i>	12. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
13. FATHER'S NAME <i>John W Tracey</i>	14. MOTHER'S MAIDEN NAME <i>Mary A Tracey</i>							
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or none) <i>No</i>	17. SOCIAL SECURITY NO. <i>MC</i>	INFORMANT <i>Geo J. Tracy - St Dennis Ned</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>GENERALIZED ARTERIOSCLEROSIS</i> DUE TO (c) <i>CHRONIC BRONCHITIS, FRACERED KNEE CAP.</i>				INTERVAL BETWEEN ONSET AND DEATH				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>FRACERED PETELLA RT.</i>				19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING TO CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <i>FELL FORWARD</i>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>JAN 20 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>HOME</i>		(County) <i>EDENNIS BALTIMORE</i>	(State) <i>MD</i>	
21. I certify that I attended the deceased from <i>15 Nov 1969</i> to <i>2 Jan 1960</i> , that I last saw the deceased alive on <i>26 Jan 1960</i> , and that death occurred on <i>2 P.M.</i> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>George E Groleau main St Elkhridge, MD 28 Jan 60</i>				
ACTUAL SIGNATURE <i>George E Groleau</i>	DATE SIGNED <i></i>							
PHYSICIAN'S NAME (Type) <i>GEORGE - E - GROLEAU</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>1-29-60</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hempstead</i>	22d. LOCATION (City, town, or county) <i>Baltimore Co. MD</i>	(State) <i></i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie Lupton Hempstead MD</i>	ADDRESS <i></i>	24a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0415

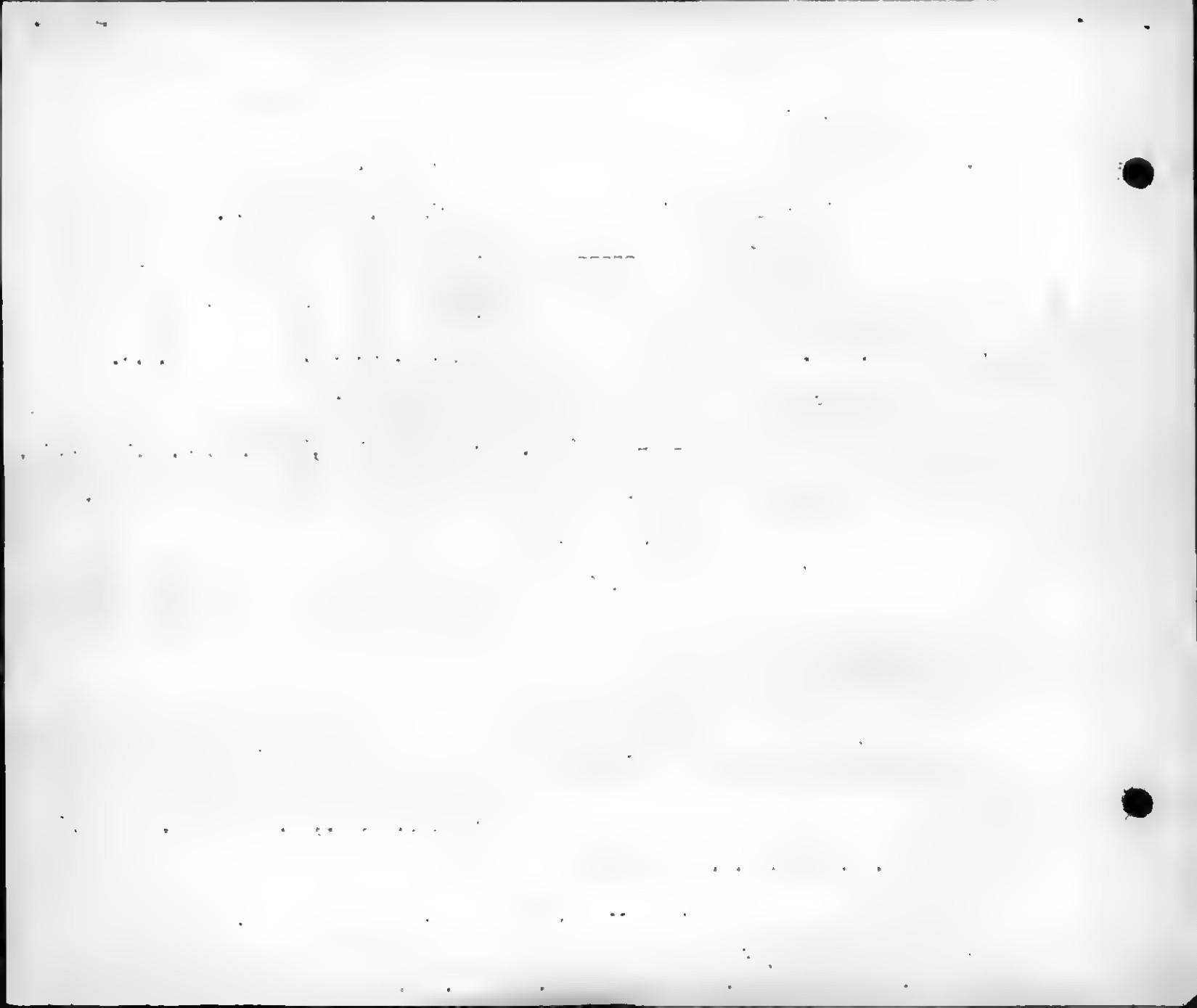
## CERTIFICATE OF DEATH

Reg. Dist. No. 10410

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE [Where deceased lived. If institution: Residence before admission] a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ft. Howard</b>		c. LENGTH OF STAY IN lb <b>6 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) <b>EUGENE</b>		First ----- <b>EUGENE</b>	Middle ----- Last ----- <b>TURNER</b>
4. DATE OF DEATH Month <b>January</b>		Day <b>23</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/5/93</b>
9. AGE (in years last birthday) <b>66 yrs.</b>	10. IF UNDER 1 YEAR Months <b>66</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry Mach. Opr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Laundry</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Turner</b>		14. MOTHER'S MAIDEN NAME <b>Rachel Estep</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-01-8737</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>171X</b>		INFORMANT Address <b>Clin. Records VA Hospital, Baltimore, Md., Ft. Howard Div.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b). <b>EMPHYSEMA OF LUNGS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>9 yrs.</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c). <b>MODERATE CACHEXIA</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>VA</b>		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>VA</b>		20e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20f. (City or town) <b>VA</b>		(County) <b>VA</b>	
(State) <b>VA</b>			
21. I certify that I attended the deceased from <b>January 17, 1960</b> , to <b>January 23, 1960</b> , and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Clyde B. Cope</b>		ADDRESS (Street, city or town, state) <b>VA Hospital, Baltimore, Md., Ft. Howard Div.</b>	
DATE SIGNED <b>1/24/60</b>			
PHYSICIAN'S NAME (Type) <b>C. B. COPE, M.D.</b>			
22. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-28-60</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles G. Cooper</b>		ADDRESS <b>512 N. CARROLLTON AVE., BALTO., MD.</b>	24a. REC'D BY REGISTRAR DATE <b>JAN 26 '60</b>
		24b. REGISTRAR'S SIGNATURE <b>Walter S. Kraus</b>	

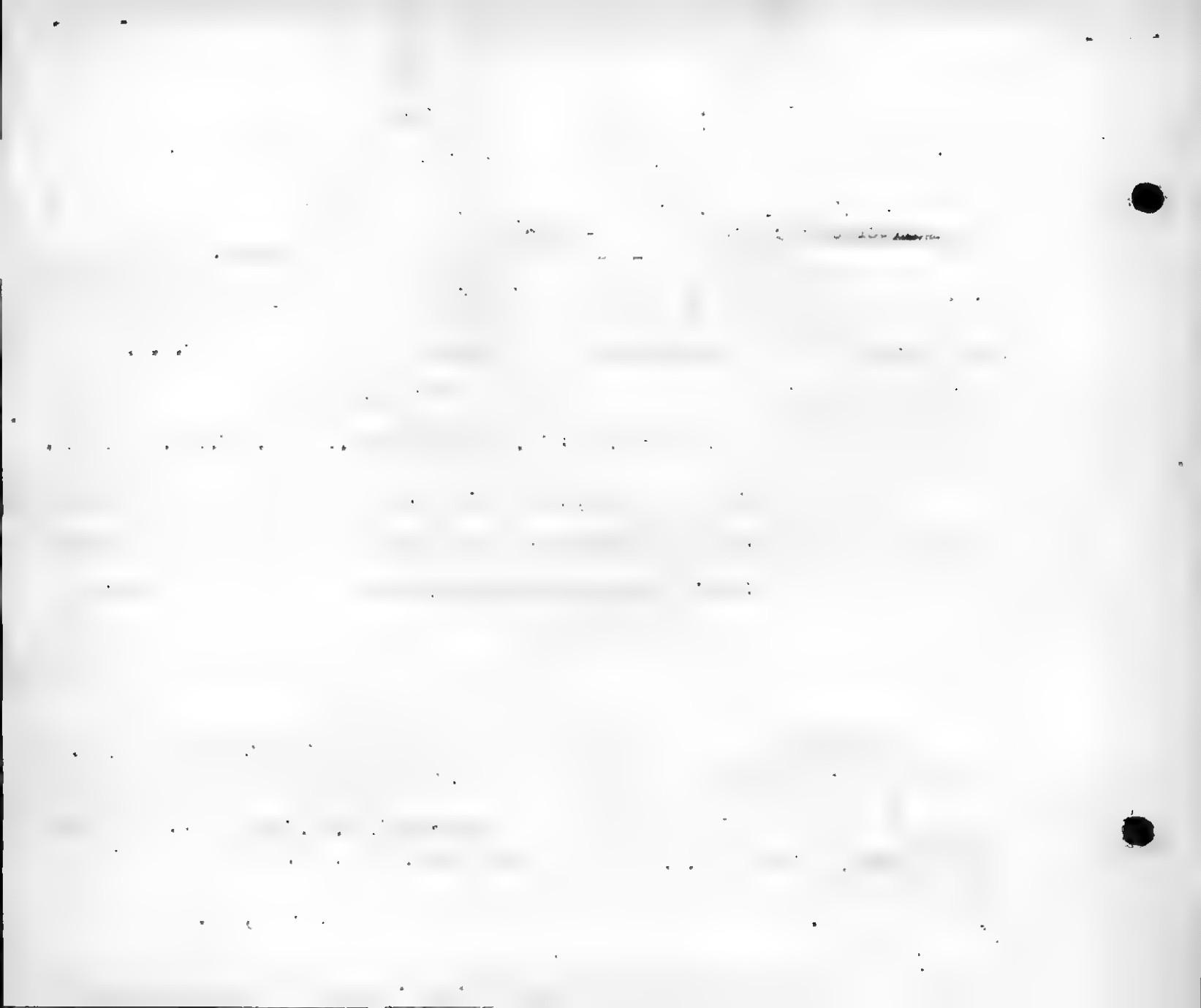


## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 10411

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Served as: <b>Anthony MIDDLE Tatalona</b> <b>ANTONIO</b> )		4. DATE OF DEATH Month <b>January</b> Day <b>13</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/16/96</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor Foreman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
10c. BIRTHPLACE (State or foreign country) <b>Italy</b>		11. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nicola Tuttolani</b>		14. MOTHER'S MAIDEN NAME <b>Rita MN: Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>216-07-8573</b>	
INFORMANT <b>Clin. Records VA Hosp., Balto., Md., Ft. Howard Div.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA, LEFT LOWER LOBE</b> <b>490X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ACUTE PYELONEPHRITIS, LEFT KIDNEY</b> <b>X99X</b> (c) <b>MARKED FATTY INFILTRATION OF LIVER</b> <b>X99X</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1 WEEK</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G.VEN IN PART 1(a) <b>UNKNOWN</b>			
19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that attended the deceased from <b>January 8, 1960</b> , to <b>January 13, 1960</b> , and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>John W. Crawford</b> ACTUAL SIGNATURE M.D. <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION 1/14/60</b>			
DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> M.D. <b>VAH, BALTO. 18, MD. FT. HOWARD DIVISION</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Bellotti Jr.</b>		ADDRESS <b>322 S. HIGH ST.</b>	
		24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>Charles L. Thomas</b>	
DALLA NOCE FUNERAL HOME, 322 S. HIGH ST., BALTO., MD.			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0417 CERTIFICATE OF DEATH

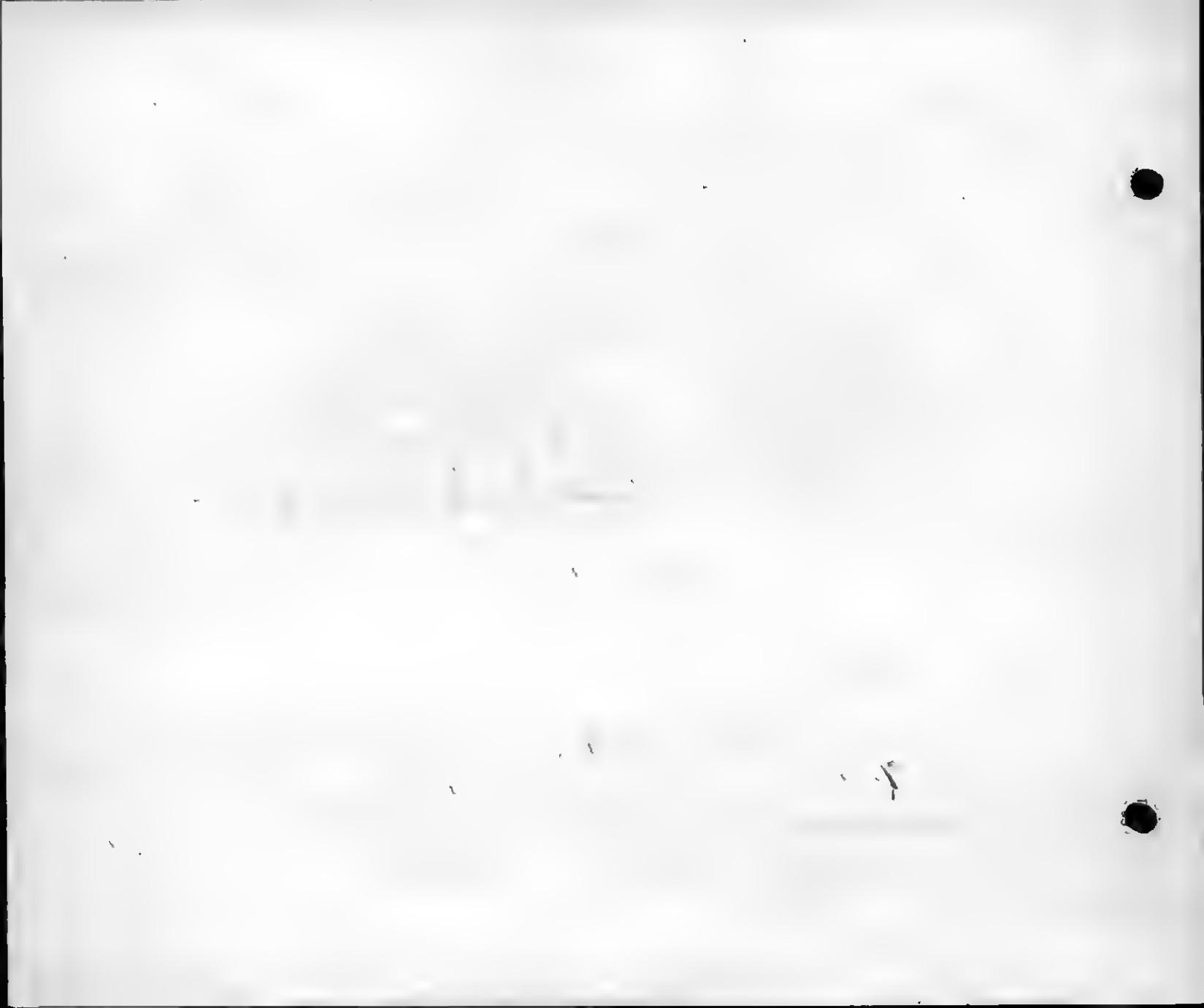
Reg. Dist. No.

00412

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>2 Augburt Road</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>	
3. NAME OF (Type or print) <i>MARY-R-UPPERCO</i>		4. DATE OF DEATH <i>Jan 10</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 1-1859</i>
9. AGE (In years last birthday) <i>101 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i>	11. IF UNDER 24 HRS Hours <i>0</i> Min <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Trick.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
10c. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Nash</i>		14. MOTHER'S MAIDEN NAME <i>Matilda Cole</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Miss May Upperco - Towson Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO  (c) <i>Arteriosclerosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>None</i>
20f. (City or town) <i>None</i>		(County) <i>None</i> (State) <i>None</i>	
21. I certify that I attended the deceased from <i>Sept 12, 1958</i> , to <i>Jan 10, 1960</i> , that I last saw the deceased alive on <i>Jan 10, 1960</i> and that death occurred at <i>9:30 AM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Laurence C. Post, M.D.</i>		ADDRESS (Street, city or town, state) <i>6005 York Rd., Baltimore 12 Md</i>	
DATE SIGNED			
PHYSICIAN'S NAME (Type) <i>Laurence C. Post</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>1-13-60</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Paul's</i>
22d. LOCATION (City, town, or county) <i>Upperco Baltimore Md</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edee G. Tipton Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 14 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0413

## CERTIFICATE OF DEATH

00413

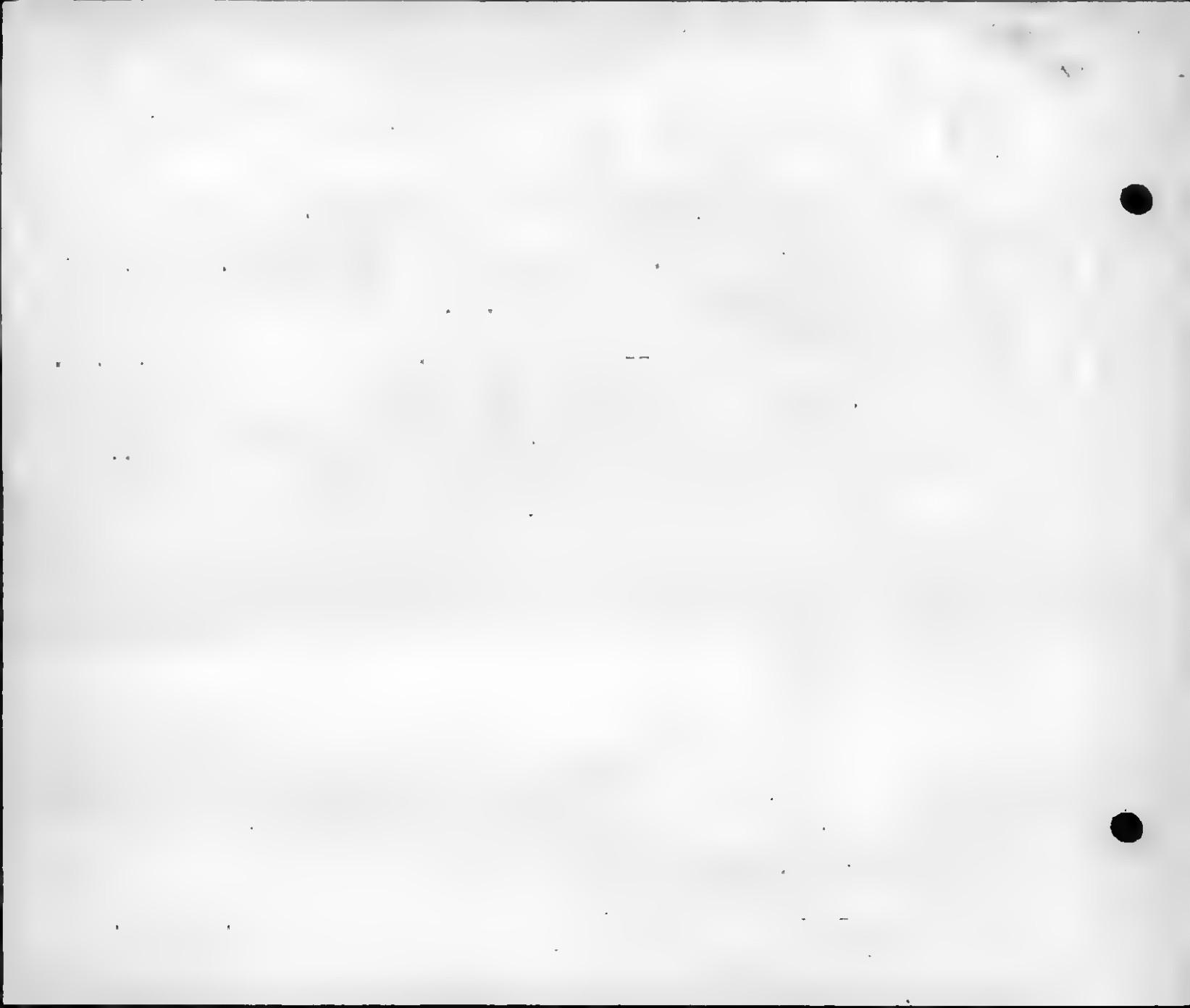
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN lb <b>20 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Woodlawn</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Ridgeway Manor Nursing Home</b>		d. STREET ADDRESS <b>2000 Mosby Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)	First <b>Annie</b>	Middle <b>M.</b>	Last <b>Vaughn</b>	4. DATE OF DEATH	Month <b>Jan.</b>	Day <b>18,</b>	Year <b>1960</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 14, 1882</b>	9. AGE (In years last birthday) <b>77</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>	Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>...</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>William E. Bensel</b>				14. MOTHER'S MAIDEN NAME <b>Mary Rapp</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT		Address <b>Elizabeth Bensel 2000 Mosby Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> DUE TO <b>26.0X</b> Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Diabetes Mellitus</b> (c) <b>Arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>7 hr.</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>November 1959</b> to <b>Jan 16, 1960</b> that I last saw the deceased alive on <b>Jan 11, 1960</b> , and that death occurred at <b>12:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>E. E. Wells</b> ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <b>George E. Wells</b> DATE SIGNED <b>410 Edmondson Ave., 1-19-60</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-21-1960</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Lorraine Park</b>		22d. LOCATION (City, town, or county) <b>Woodlawn</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Howard Strong</b>		ADDRESS <b>32 of W. North Ave.,</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00414

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the same, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PK3. Page 5 may be retained by your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		64-8 BALTO.	Reg. Dist. No.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)	
c. LENGTH OF STAY IN lb			a. STATE	MD
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			b. COUNTY	BALTO.
e. NAME OF DECEASED (Type or print)		First Randolph	Middle Charles	3. DATE OF DEATH
f. SEX		COLO/D RACE white	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	DATE OF DEATH January 14 1960
g. DATE OF BIRTH		10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood worker	10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 80 yrs
			11. BIRTHPLACE (State or foreign country) Maryland	12. IF UNDER 1 YEAR Months Days Hours Min
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO	17. INFORMANT Mabel Voltmer wife some	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		STROKE - Cerebral vascular occlusion assumed		
4. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)		Atherosclerotic Cardiovascular Disease and		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>John C. Hyle</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
EXAMINER'S NAME (Type) <i>John C. Hyle</i>		DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 1/18/60	22c. NAME OF CEMETERY OR CREMATORIUM Crownover Cemetery	22d. LOCATION (City, town, or county) White Plains, N.Y. (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John C. Hyle</i>		ADDRESS 100 W. Main St., White Plains, N.Y.	24a. REC'D BY REGISTRAR JAN 18 '60 DATE	24b. REGISTRAR'S SIGNATURE <i>John C. Hyle</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3420

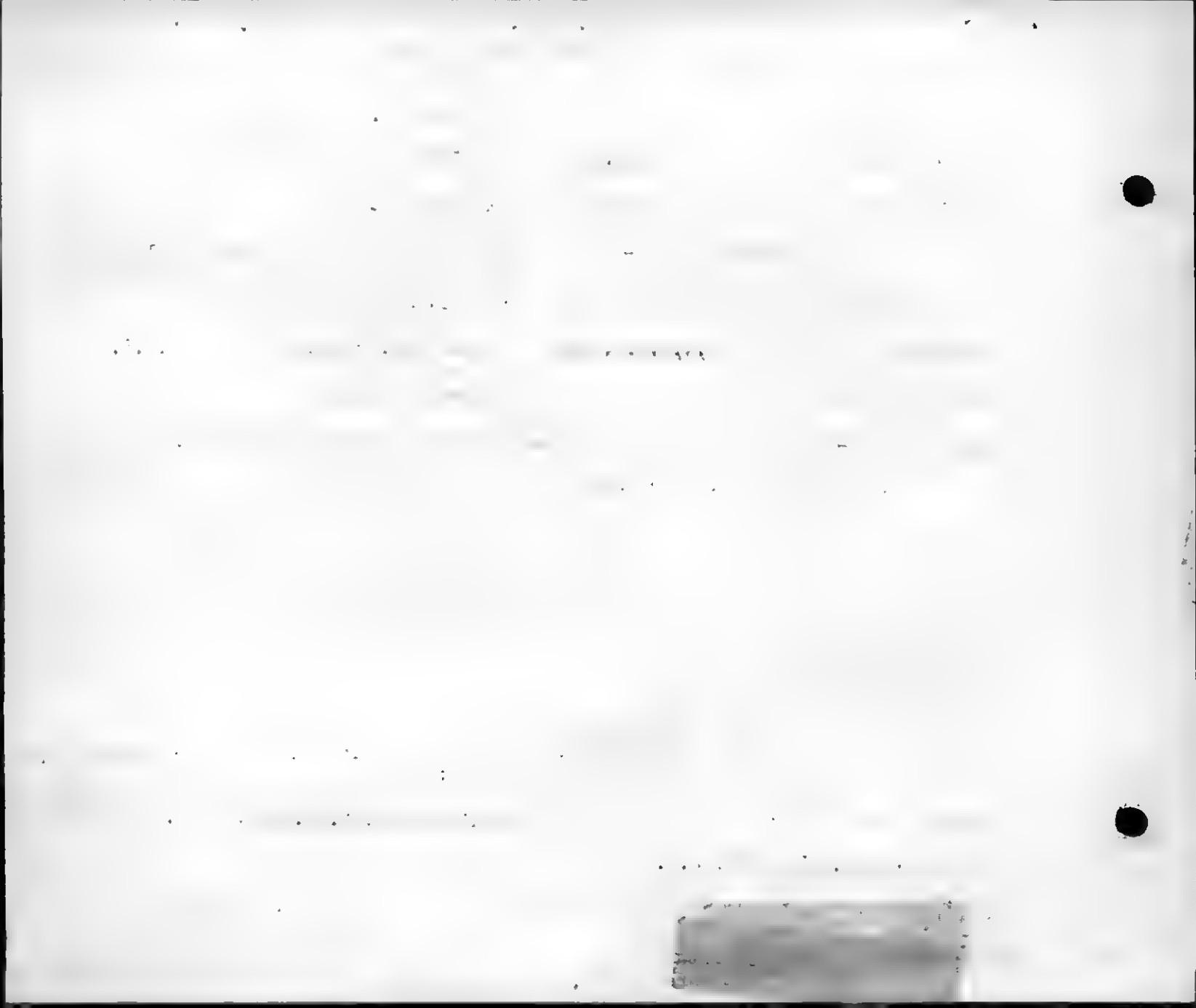
## CERTIFICATE OF DEATH

Reg. Dist. No. 00415

**TO HOSPITAL OR ATTENDING PHYSICIAN:** This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
BALTIMORE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c LENGTH OF STAY IN lb	b. COUNTY	
FORT HOWARD	60 Days	MARYLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
VETERANS ADMINISTRATION HOSPITAL		BALTIMORE	
3. NAME OF DECEASED (Type or print)	First JOSEPH	Middle ---	Last VYKOUKAL
4. DATE OF DEATH	Month JANUARY	Day 11	Year 1960
5. SEX MALE	6 COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST		10b. KIND OF BUSINESS OR INDUSTRY U.S. Coast Guard	
10c. FATHER'S NAME JAMES VYKOUKAL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? YES		14. MOTHER'S MAIDEN NAME JOSEPHINE PAKIR	
15. SOCIAL SECURITY NO. WW-11		INFORMANT CLIN REC VAH BALTO MD FT HOWARD DIVISION	
Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LYMPHOSARCOMA		INTERVAL BETWEEN ONSET AND DEATH 1-1/2 YEARS	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 12, 1959, to January 11, 1960, <del>had no access to the deceased</del> , <del>and that death occurred at 7:30 pm, from the causes and on the date stated above.</del>		ADDRESS (Street, city or town, state) M.D. VAH, BALTO 18, MD. FT. HOWARD DIV. 1/12/60	
ACTUAL SIGNATURE John W. Crawford		DATE SIGNED 1/12/60	
PHYSICIAN'S NAME (Type) JOHN W. CRAWFORD, M.D.			
22a. BURIAL, CREMATION REMOVAL (Specify) BURIAL		22b. DATE THEREOF 1/12/60	
22c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		22d. LOCATION (City, town, or county) BALTIMORE, MARYLAND	
23. FUNERAL DIRECTOR McCULLY FUNERAL HOME, 237 Patapsco Ave Baltimore 25, Md.		24a. REC'D'D BY REGISTRAR JAN 14 '60	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0421

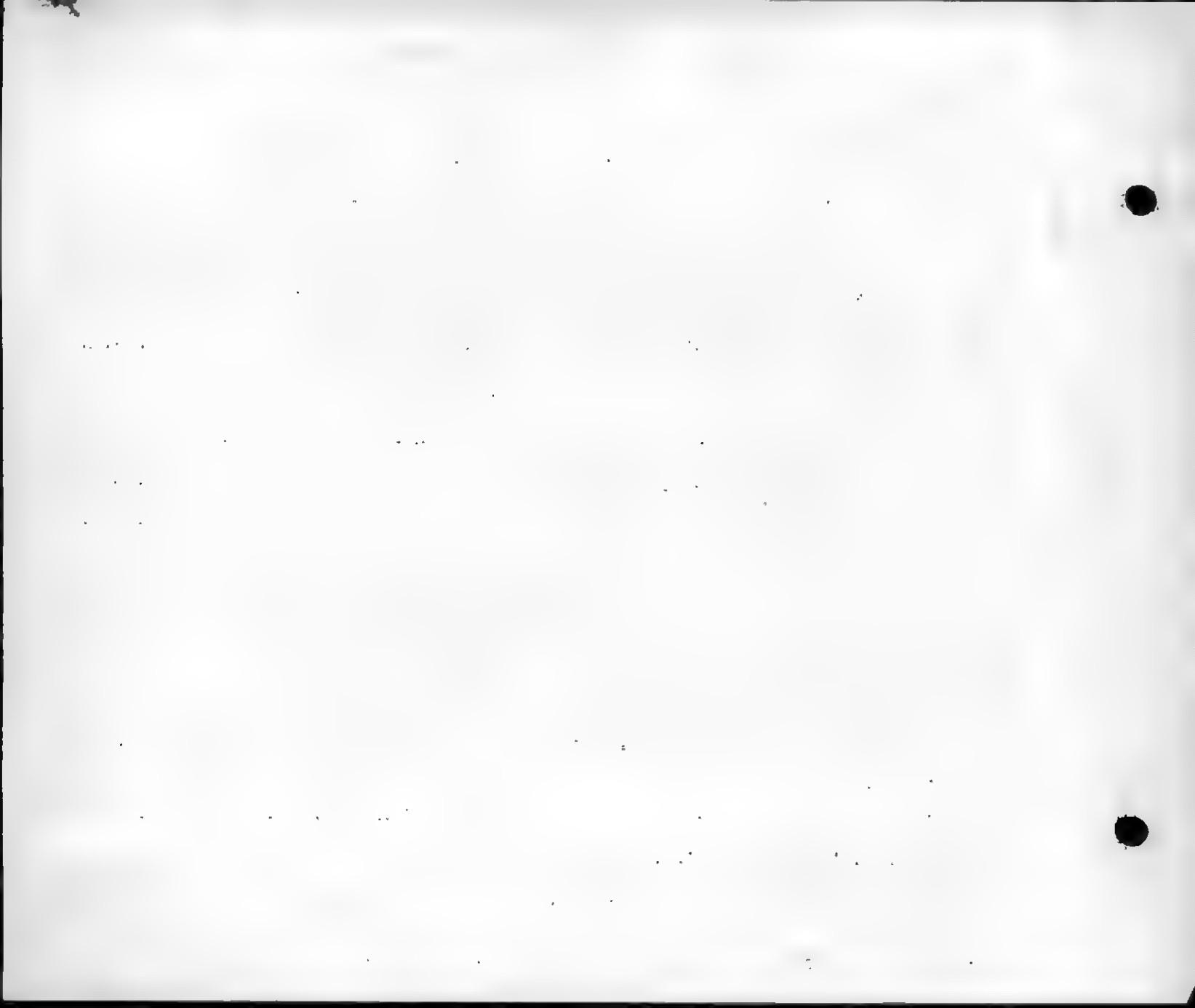
## CERTIFICATE OF DEATH

Reg. Dist. No.

00416

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal; and in any event within 2 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>22 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		d. STREET ADDRESS <b>2303 Washington Boulevard</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>KENNETH</b>		First <b>KENNETH</b>	Middle <b>- - -</b>	Lost <b>WARREN</b>	4. DATE OF DEATH <b>January 20 1960</b>	Month <b>January</b>	Day <b>20</b>	Year <b>1960</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1921</b>	9. AGE (In years last birthday) <b>38</b> yrs.	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>	13. IF UNDER 24 HRS Min <b>0</b>
10a. US JA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Trucking</b>		11. BIRTHPLACE (State or foreign country) <b>Wilmington, N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.A.</b>		
13. FATHER'S NAME <b>James E. Warren</b>			14. MOTHER'S MAIDEN NAME <b>Iula Tippen</b>			Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>WW II</b>		INFORMANT <b>Clin. Rec. VAH, Balto. 18, Md. Ft. Howard Division</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>XXXXXX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)								
INTERVAL BETWEEN ONSET AND DEATH <b>3 WEEKS</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RECENT								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>December 29, 1959</b> , to <b>January 20, 1960</b> , <b>xVA</b> , and that death occurred at <b>1:40P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>VAH, BALTO.18, MD. FT. HOWARD DIV.</b>								
ACTUAL SIGNATURE <b>W. J. PIJANOWSKI</b> DATE SIGNED <b>1/21/60</b>								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>75 JAN 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b> <b>Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edward Towson, 2359 Washington Blvd, Balto. Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Oliver S. King</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0422 CERTIFICATE OF DEATH

Reg. Dist. No.

00417

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cockeysville</b>		c. LENGTH OF STAY IN lb <b>20 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>York Rd.</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cockeysville</b>	
f. STREET ADDRESS <b>/ York Rd.</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Howard Egerton</b>	Middle <b>Watkins</b>	Last
4. DATE OF DEATH	Month <b>1-28-60</b>	Day	Year <b>19</b>
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-10-1910</b>
9. AGE (in years last birthday) <b>49</b> yrs	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>owner operator</b>	11. KIND OF BUSINESS OR INDUSTRY <b>gasoline station</b>	12. BIRTHPLACE (State or foreign country) <b>New Jersey</b>
13. FATHER'S NAME <b>Howard Watkins</b>	14. MOTHER'S MAIDEN NAME <b>Florence Dickinson</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>215-05-4615</b>	INFORMANT <b>Mary K. Watkins</b>	Address <b>above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>331X</b> DUE TO <b>Massive Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr.</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gen. Arteriosclerosis</b> ? (c) <b>Chro. Hypertension</b> ?			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Part II</b> <b>None</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>alive on</b> <b>5-28-1960</b> , and that death occurred at <b>10:10 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>M.D. 310-59 Charles St.</b> DATE SIGNED <b>Brattinway 18-746</b>			
ACTUAL SIGNATURE <b>P. H. Silver</b>	PHYSICIAN'S NAME (Type) <b>P. H. Silver</b>		
22a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1-30-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Loudon Park</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Brooks Funeral Service, Towson 4, Md.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>FEB 1 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0423

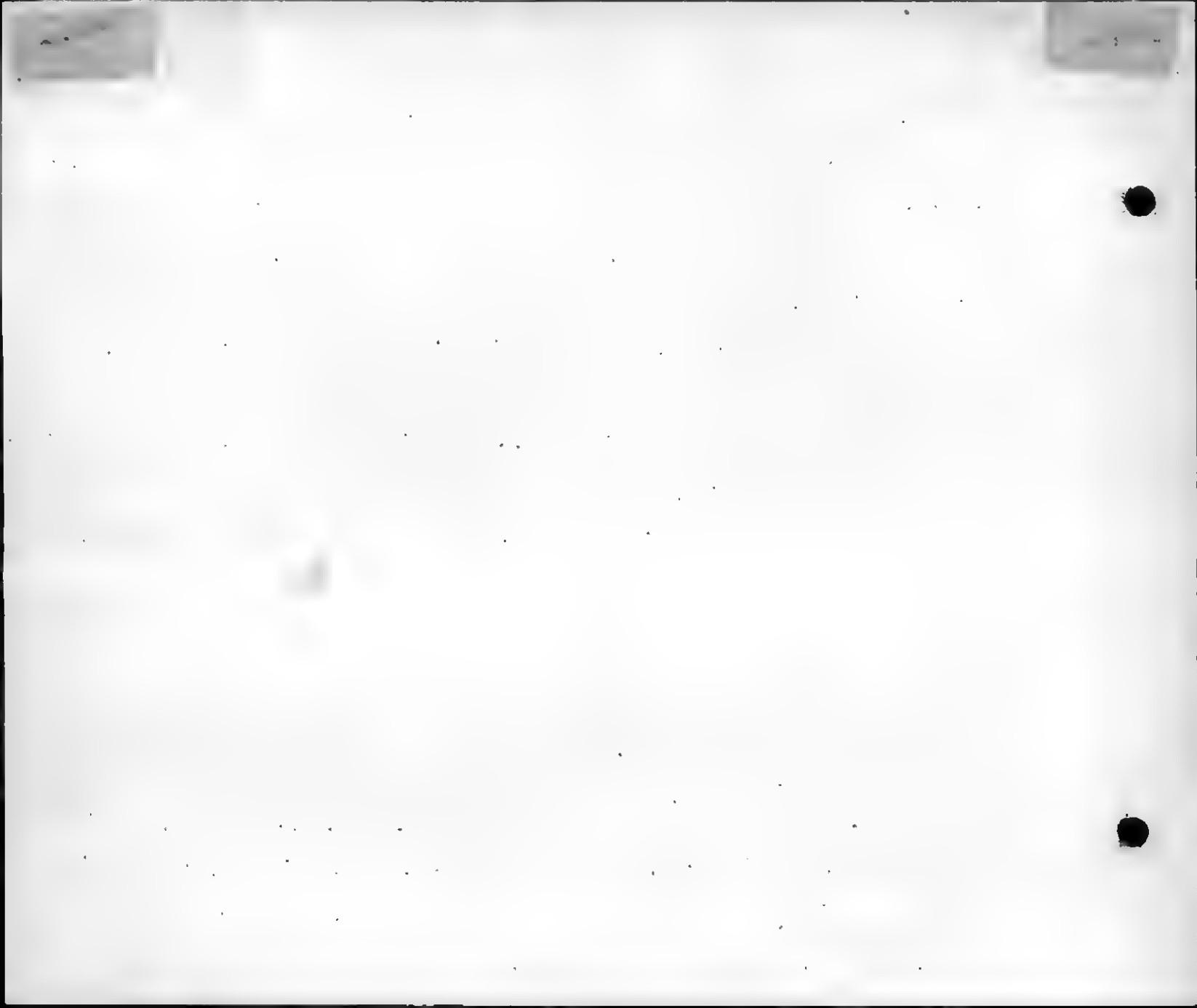
## CERTIFICATE OF DEATH

Reg. Dist. No.

00418

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>41 Days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>BASIL</b>	Middle <b>M.</b>	Last <b>WEBSTER</b>
4. DATE OF DEATH	Month <b>January</b>	Day <b>4</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 21, 1911</b>
9. AGE (In years lost birthday) <b>48 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Janitor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Edgewood Arsenal</b>	
11. BIRTHPLACE (State or foreign country) <b>Atlantic City, N. Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harry Webster</b>		14. MOTHER'S MAIDEN NAME <b>Fannie Shorter</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>150-07-5009</b>	
17. INFORMANT <b>Clin. Rec., VAH, Baltimore 18, Md. Ft. Howard Division</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 24, 1959, to January 4, 1960, and that death occurred at 6:05 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>John W. Crawford</i> PHYSICIAN'S NAME (Type) <b>JOHN W. CRAWFORD, M.D.</b> M.D. VAH, BALTO. 18, MD. FT. HOWARD DIV. 1/5/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-8-60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>George Kelson</i>		24a. REC'D BY REGISTRAR DATE <b>JAN 6 '60</b>	
ADDRESS <b>George Kelson, 1348 N. Calhoun St/Balto. Md.</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>	



1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**may be reported by the hospital or attending physician.**

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

0425

**CERTIFICATE OF DEATH**

00413

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>COCKEYSVILLE</b>		c. LENGTH OF STAY IN 1b <b>3 YEARS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MASONIC HOME</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>	
3. NAME OF DECEASED (Type or print) <b>EVA</b>		First <b>GOOTEE</b>	Middle <b>WEIGLE</b>
4. DATE OF DEATH <b>JAN 18 1960</b>	Month <b>JAN</b>	Day <b>18</b>	Year <b>1960</b>
5. SEX <b>FE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-1880</b>
9. AGE (in years last birthday) <b>79 yrs.</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b>	12. IF UNDER 24 HRS. Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>JAMES H. HUBBARD</b>		14. MOTHER'S MAIDEN NAME <b>GRACE GOOTEE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO <b>212-07-0186-D</b>	
17. INFORMANT <b>Frank P. Smith Jr., Cockeysville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH  <i>Atherosclerotic Cardio</i> <i>Vascular Disease</i> <b>3 yrs.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>3-9-56</b> to <b>1-18</b> , 1960, that (I) (we) lost saw the deceased alive on <b>1-18 1960</b> , and that death occurred at <b>11:45PM</b> from the causes and on the date stated above			
22a. SIGNATURE <i>Walter T. Kees</i>		M.D. <input type="checkbox"/> ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>	22b. DATE SIGNED <b>1/8/60</b>
22c. PHYSICIAN'S NAME (Type) <b>WALTER T. KEEPS</b>		22d. ADDRESS <b>COCKEYSVILLE, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>1-21-60</b>	23c. NAME OF CEMETERY OR CREMATORIAL <b>Western Cemetery</b>
23d. LOCAT ON (City, town, or county) <b>Baltimore, Maryland</b>		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Avenue</b>	25a. REC'D BY REGISTRAR DATE <b>JAN 21 '60</b>
25b. REGISTRAR'S SIGNATURE <b>Carrie S. Turner</b>			

1921

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 111420

1. PLACE OF DEATH o. COUNTY <b>Baltimore</b>		2 USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Parkville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>9848 Harford Rd</b>	d. STREET ADDRESS <b>9848 Harford Rd</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Rosa</b>	First	Middle	Last <b>Welch</b> Month <b>Jan.</b> Day <b>17</b> Year <b>1960</b>	
5 SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-19-1870</b> 9. AGE (In years lost birthday) <b>89</b> yrs IF UNDER 1 YEAR Months <b>89</b> Days Hours <b>0</b> Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Brunn</b>		14. MOTHER'S MAIDEN NAME <b>Maria Reimalt</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <b>Chas. Welch</b> of same Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (o.) <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (o.), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o.) <b>Congestive heart failure with Myocarditis Chronic 10+ yrs Myocardial degeneration?</b> <b>Generalized arteriosclerosis</b>				
20a. ACCIDENT WAS UNDERLYING-CAUSE OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. P. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>9005 Harford Rd</b>	20f. (City or town) <b>BALTO</b> (County) <b>MD</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Jan 8, 1960</b> to <b>Jan 17, 1960</b> , that I last saw the deceased alive on <b>Jan 16, 1960</b> , and that death occurred at <b>4 AM</b> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <b>FRANK T. KASIK Jr.</b>	ADDRESS (Street, city or town, state) <b>9005 Harford Rd BALTO MD</b> DATE SIGNED <b>1/18/60</b>			
PHYSICIAN'S NAME (Type) <b>FRANK T. KASIK</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	22b. DATE THEREOF <b>1-19-60</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Loudon Park</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Leonard J. Ruck 5305 Harford Rd</b>		ADDRESS <b>Leonard J. Ruck 5305 Harford Rd</b>	24a. REC'D BY REGISTRAR DATE <b>JAN 19 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Albert S. Kassik</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00421

0426

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 55 Towson				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8114 Kirkwall Ct.			d. STREET ADDRESS 8114 Kirkwall Ct.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print)	First Mary	Middle L.	Last Welker	4. DATE OF DEATH January	Month 6	Day 19	Year 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 12, 1917	9. AGE (In years at birthday) 42 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher			10b. KIND OF BUSINESS OR INDUSTRY Balto. Co. Dept. Ed.	11. BIRTHPLACE (State or foreign country) Cambridge, Ohio			12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John McPherson			14. MOTHER'S MAIDEN NAME Laura Smith					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 278-14-3710		17. INFORMANT Francis Welker		Address 8114 Kirkwall Ct.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Breast Carcinoma						INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ AM, from the causes and on the date stated above.						ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE <i>Franklin E. Lofie</i>		M.D.		<i>2929 N. Charles St.</i>			DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>Franklin E. Lofie</i>		<i>Baltimore 18, Md</i>						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/ 9/60		22c. NAME OF CEMETERY OR CREMATORIUM West Lafayette		22d. LOCATION (City, town, or county) Newcomerstown Ohio		
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook-Towson Inc. 1050 York Rd. #4			ADDRESS			24a. REC'D BY REGISTRAR DATE JAN 8 '60	24b. REGISTRAR'S SIGNATURE <i>Ernest S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1c Film G255 1-27-60 st  
 0427

## CERTIFICATE OF DEATH

Reg. Dist. No.

00422

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CATONSVILLE</b>		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE HOSP</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY</b>	
3. NAME OF DECEASED (Type or print) <b>BESSIE</b>		First <b>WENTZ</b>	Middle <b></b>
4. DATE OF DEATH <b>JAN. 18, 1960</b>	Month <b>JAN.</b>	Day <b>18</b>	Year <b>1960</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-21-88</b>
9. AGE (In years last birthday) <b>71</b> yrs.	10. KIND OF BUSINESS OR INDUSTRY Dept. <b>Store</b>	11. BIRTHPLACE (State or foreign country) <b>BALTO.</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Wentz</b>	14. MOTHER'S MAIDEN NAME <b>Josephine Gruender</b>	Address <b>4905 Denmore Ave.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNHUNWN</b>	INFORMANT <b>Mrs. M. M. WENTZ</b>
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute cardiac failure</b>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 18, 1960</b> , to <b>Jan. 20, 1960</b> that I last saw the deceased alive on <b>Jan. 20, 1960</b> , and that death occurred at <b>6:40 AM</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Spring Grove Hospital</b>	
ACTUAL SIGNATURE <b>Stella Wachsler</b>		DATE SIGNED <b>1-20-60</b>	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catoonsville 28, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/23/60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Cathedral Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>b. Vernon Lummis</b>	ADDRESS <b>4611 Park Heights, Balto. Md.</b>	24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 File No. 4-1-60-60 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00423

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MD</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Marsh</i>		c. LENGTH OF STAY IN 1b <i>White Marsh</i>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Allender Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>White Marsh</i>				
d. STREET ADDRESS <i>Allender Road</i>		d. STREET ADDRESS <i>Allender Road</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <i>Alice</i>		First <i>A</i>	Middle <i>White</i>			
4. DATE OF DEATH <i>January 12</i>		Month <i>January</i>	Day <i>12</i>			
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <i>1871</i>		9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>at home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>W</i>	11. BIRTHPLACE (State or foreign country) <i>W Va</i>			
12. CITIZEN OF WHAT COUNTRY? <i>W Va</i>						
13. FATHER'S NAME <i>Jacob White</i>		14. MOTHER'S MAIDEN NAME <i>Delia Stump</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>Address</i>				
17. INFORMANT <i>Austin White 17 N Chester St</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <i>1 p.m. - 1 19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>W Va</i>	20f. (City or town) <i>Baltimore</i>	(County) <i>Baltimore</i>	(State) <i>MD</i>
21. I certify that I attended the deceased from <i>1-15</i> , 19 <i>57</i> , to <i>1-12</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>1-12</i> , 19 <i>60</i> , and that death occurred at <i>1-12</i> , 19 <i>60</i> . M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Gerald C Palmer</i>		ADDRESS (Street, city or town, state) <i>Baltimore, MD</i>		DATE SIGNED <i>1-13-60</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Removal Jan 14/60</i>		22b. DATE THEREOF <i>14/60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mount Olivet</i>	22d. LOCATION (City, town, or county) <i>Roseburg W Va</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ullman Funeral Home 4210 Belair Rd</i>		ADDRESS <i>Ullman Funeral Home 4210 Belair Rd</i>		24a. REC'D BY REGISTRAR DATE <i>JAN 15 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Cinda S. Tracy</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

00424

1 X 2 3 I 4		0423		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.											
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.		TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.													
1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		3. NAME OF DECEASED First Harry Middle James Last Wilson		4. DATE OF DEATH Month January Day 11 Year 1960									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr 7mth 26dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 3102 Virginia Avenue		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 5, 1887		9. AGE (in years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maintenance man		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME Edward James Wilson		14. MOTHER'S MAIDEN NAME Theresa ? CARNEY		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Army		16. SOCIAL SECURITY NO. 130-8805		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Due to (c)		19. INTERVAL BETWEEN ONSET AND DEATH days			
20a. MEDICAL CERTIFICATION		20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from _____		March 22, 1958, to 1-11, 1960, that I last saw the deceased alive on 1-10, 1960, and that death occurred at 2:45 A.M. from the causes and on the date stated above.		ACTUAL SIGNATURE Stella Wachsler		ADDRESS (Street, city or town, state) M.D. SPRING GROVE STATE HOSPITAL		DATE SIGNED 1-01-60							
PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/13/60		22c. NAME OF CEMETERY OR CREMATORIAL BALTO. NATIONAL CEM.		22d. LOCATION (City, town, or county) BALTO. Maryland		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE S. Truman Schwalb		ADDRESS 7512 Fred. Ave.		24a. REC'D BY REGISTRAR DATE JAN 13 '60		24b. REGISTRAR'S SIGNATURE Edmund S. Timm									



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0430

## CERTIFICATE OF DEATH

Reg. Dist. No.

00425

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours of death. Page 4 may be read by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

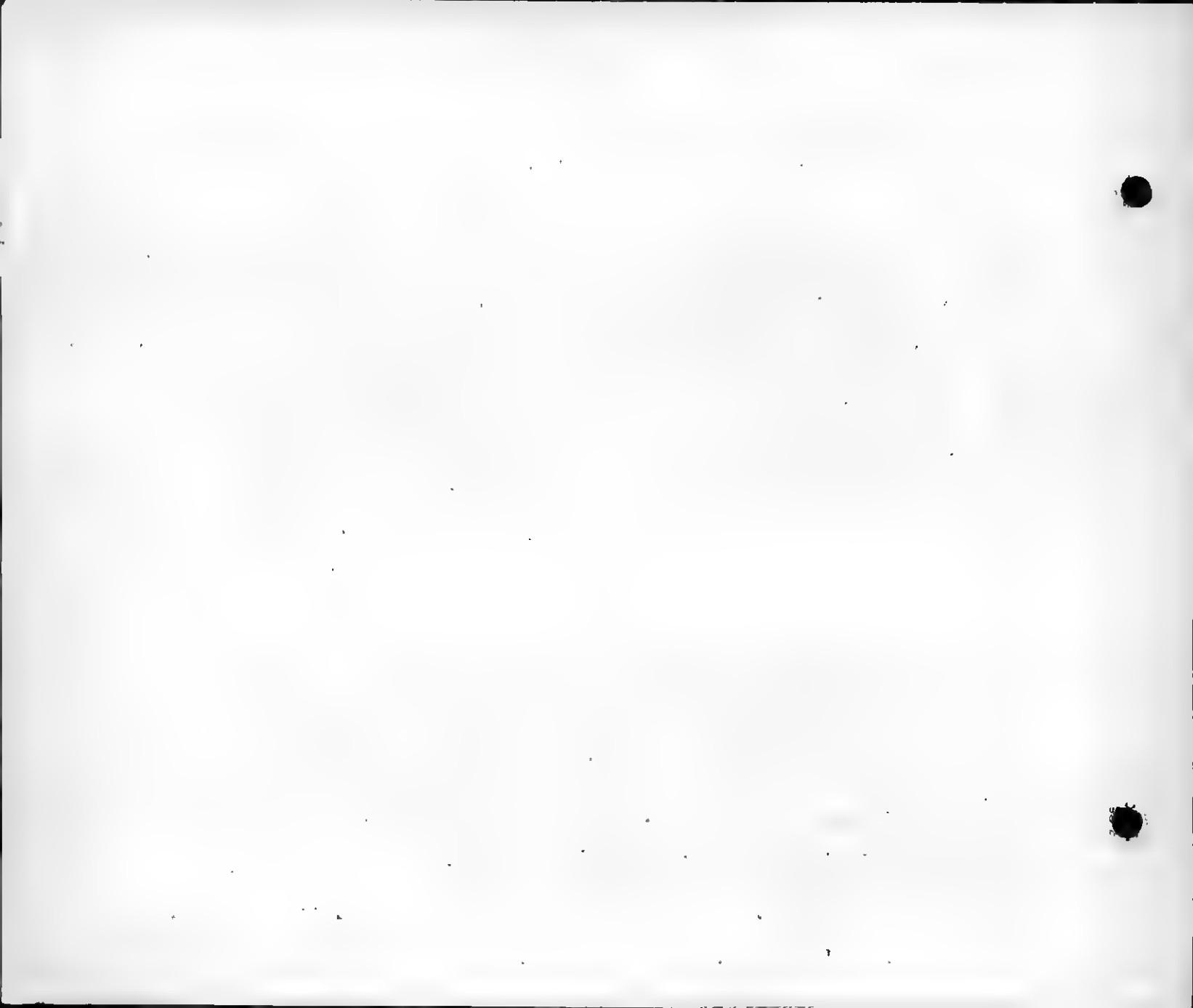
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Owings Mills</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Owings Mills, Maryland</b>		d. STREET ADDRESS <b>10827 Reisterstown Road</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Laura Jane Wimsett</b>		First	Middle	Last	4. DATE OF DEATH <b>January 24, 1960</b>	Month	Day	Year	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 24, 1874</b>		9. AGE (in years less birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min. 11. IF UNDER 24 HRS		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Stevenson, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Milton Hood</b>				14. MOTHER'S MAIDEN NAME <b>Aletta Brown</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>123-12-1212</b>		INFORMANT <b>Ins. I. un. A. Reiner, 12027</b>		Address <b>12027</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>(b)</b> DUE TO <b>Pneumonia - Hypostatic</b> <b>40 days</b> <b>(c)</b> DUE TO <b>Hypogastritis - ob comparsy</b> <b>5 yrs</b> DUE TO <b>Washed general arteriosclerosis</b> <b>3 yrs</b>						INTERVAL BETWEEN ONSET AND DEATH			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18]				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>11A</b>		20f. (City or town) <b>Baltimore</b>		(County) <b>Baltimore</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>1-1-1960</b> to <b>1-24-60</b> , that I last saw the deceased alive on <b>1-24-60</b> , and that death occurred at <b>11A</b> M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b>		DATE SIGNED <b>Feb 1-26-60</b>	
ACTUAL SIGNATURE <b>James G. Siffell</b>									
PHYSICIAN'S NAME (Type) <b>James G. Siffell M.D. Reisterstown MD</b>									
22d. BURIAL, CREMAT. ON, REMOVAL (Specify) <b>27, 1960</b>		22b. DATE THEREOF <b>27, 1960</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) <b>Baltimore</b>		(State) <b>Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Miller (P.M.)</b>		ADDRESS <b>10827 Reisterstown Rd.</b>		24e. REC'D BY REGISTRAR <b>JAN 29 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carroll S. Kline</b>			



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**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

<b>MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18</b>															
<b>CERTIFICATE OF DEATH</b>															
Reg. Dist. No. 00426															
1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>				c. LENGTH OF STAY IN lb <b>lyrlmth23dys</b>				d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>				d. STREET ADDRESS <b>1511 Open Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First <b>Frank</b>		Middle Winkler		Lost		4. DATE OF DEATH	Month <b>Jan.</b>	Doy <b>8,</b>	Year <b>1960</b>				
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 7, 1875</b>		9. AGE (In years lost birthday) <b>84 yrs.</b>	IF UNDER 1 YEAR Months <b>8</b>	IF UNDER 24 HRS Days <b>0</b>	Hours <b>0</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>plumber</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13 FATHER'S NAME <b>John Winkler</b>						14 MOTHER'S MAIDEN NAME <b>Malina ?</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>Unknown</b>		INFORMANT		Address <b>R. cords: SPRING GROVE STATE HOSPITAL</b>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)  <i>42a.1</i> <b>Cardiac failure.</b>															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)  <i>Arterioscler. Cardio Vas. Disease</i>															
DUE TO (c)  <i>Arteriosclerosis, atheroscler. &amp; vaso-</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>Nov. 25, 1958</b> to <b>1/18/60</b> , 1960, that I last saw the deceased alive on <b>1-8-60</b> , 1960, and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Catonsville 28, Maryland</b>												DATE SIGNED			
ACTUAL SIGNATURE <b>Stella Wachsl ~</b>		M.D. <b>SPRING GROVE STATE HOSPITAL</b>													
PHYSICIAN'S NAME (Type) <b>Stella Wachsl ~</b>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/11/60</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Cedar Hill Gem.</b>				22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN F. DENNY, INC. 715 Light St. -30</b>												24a. REC'D. BY REGISTRAR <b>JAN 12 1960</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Kraus</b>	
												DATE			



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00427

0432

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)	
Baltimore				a. STATE	b. COUNTY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boring		c. LENGTH OF STAY IN lb		Md. Balto.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Dover Rd.		X Boring		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dover Rd.	
e. STREET ADDRESS				d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
Edith				Wise	Jan. 19, 1960
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years last birthday) 64 yrs
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	March 9, 1895	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME George Channell		14. MOTHER'S MAIDEN NAME Unknown		12. CITIZEN OF WHAT COUNTRY USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Harry E. Wise Reisterstown, Md.	
No		None		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Arterosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH Years	
760 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)		Diabetes Mellitus		Years	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 1955 to January 19, 1960, that I last saw the deceased alive on January 18, 1960, and that death occurred at 12:45 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Clarence E. Williams</i> M.D. ADDRESS (Street, city or town, state) PHYSICIAN'S NAME (Type) <i>Reisterstown, Maryland</i> DATE SIGNED <i>January 19, 1960</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 23, 60		22c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial Gardens	
22d. LOCATION (City, town, or county) Finksburg		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Sons		ADDRESS Reisterstown, Md.		24a. REC'D BY REGISTRAR DATE JAN 21 '60	
24b. REGISTRAR'S SIGNATURE <i>C. H. J. K.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, file it in the funeral director's office. Page 3 should be detached for use as the Burial-Transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

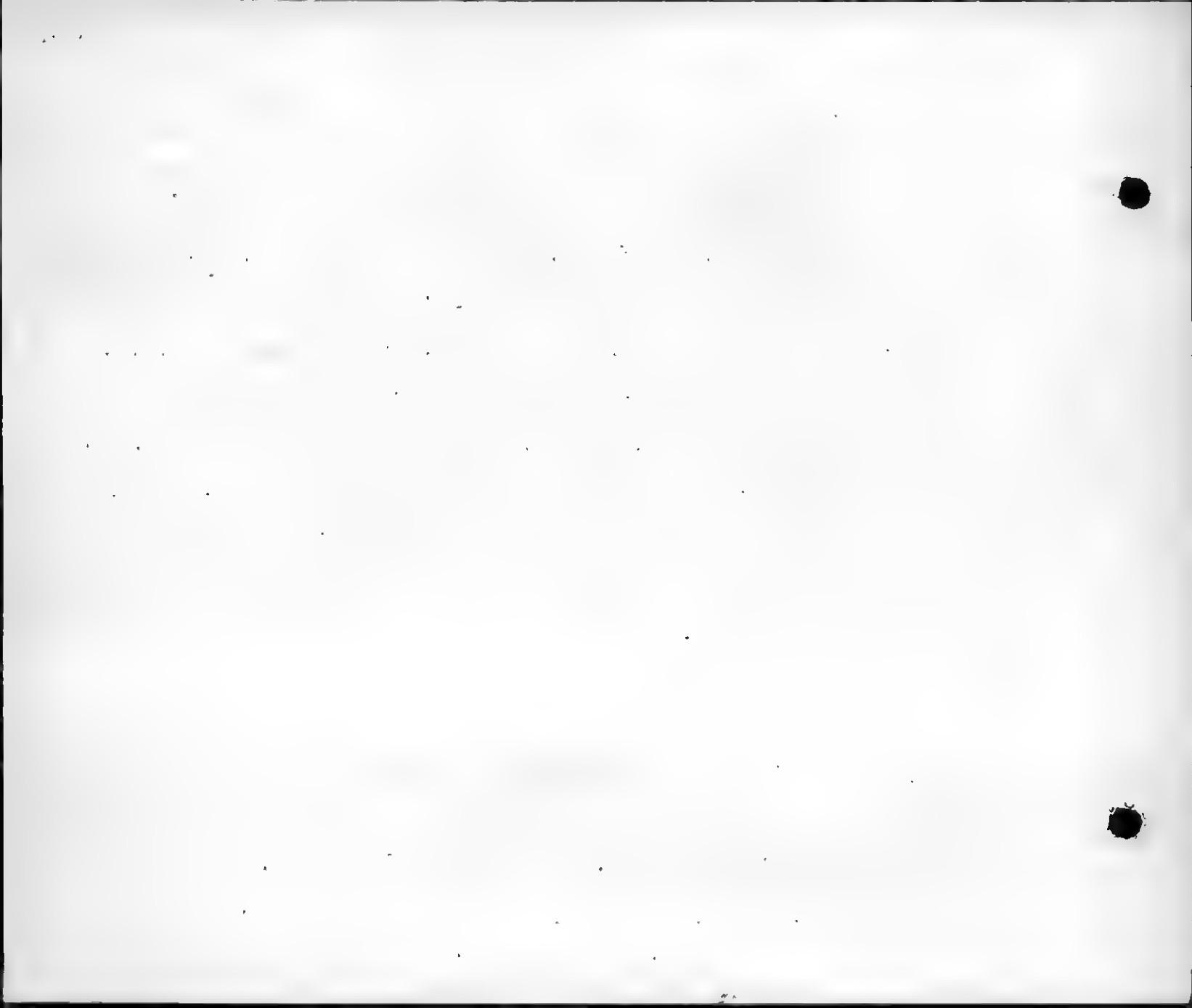
00428

## CERTIFICATE OF DEATH

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>BALTIMORE</b>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		c. LENGTH OF STAY IN 1b <b>4 Years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>8617 OAKLEIGH ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>GEORGE P. WITTS SR.</b>	Middle	Last
4. DATE OF DEATH	Month <b>JAN.</b>	Day <b>13, 1960</b>	Year <b>19</b>
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 21, 1894</b>
9. AGE (In years last birthday) <b>65 yrs.</b>	10. IF UNDER 1 YEAR Months <b>65</b>	11. IF UNDER 24 HRS Days <b>0</b>	12. IF UNDER 24 HRS Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>RETIRED</b>	11. BIRTHPLACE (State or foreign country) <b>BALTIMORE MARYLAND</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>HENRY</b>	14. MOTHER'S MAIDEN NAME <b>EMMA</b>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>	
16. SOCIAL SECURITY NO. <b>218 10 2940</b>		17. INFORMANT <b>MR. CHARLES WITTS 8617 OAKLEIGH ROAD</b>	18. ADDRESS
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY (IMMEDIATE CAUSE (a)) <b>Arterosclerotic C-V disease</b>   INTERVAL BETWEEN ONSET AND DEATH <b>6 yrs.</b> 4 x 21/4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <b>Chronic Glomerular Nephritis</b>   4 yrs' (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Chronic Bronchitis</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>May 3, 1954</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 3, 1954</b> to <b>Jan. 3, 1960</b> that I last saw the deceased alive on <b>Jan. 10, 1960</b> , and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.	ADDRESS (Street, city or town, state) <b>1520 E. 33rd St.</b>		DATE SIGNED <b>1-14-60</b>
ACTUAL SIGNATURE <b>Wm. H. Grenzer M.D.</b>	PHYSICIAN'S NAME (Type) <b>W. H. GRENZER</b>		
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>Jan. 18, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>MORELAND MEMORIAL PARK BALTIMORE MARYLAND</b>	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS INC. BALTIMORE MD.</b>	ADDRESS	24a. REC'D BY REGISTRAR DATE <b>JAN 18 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

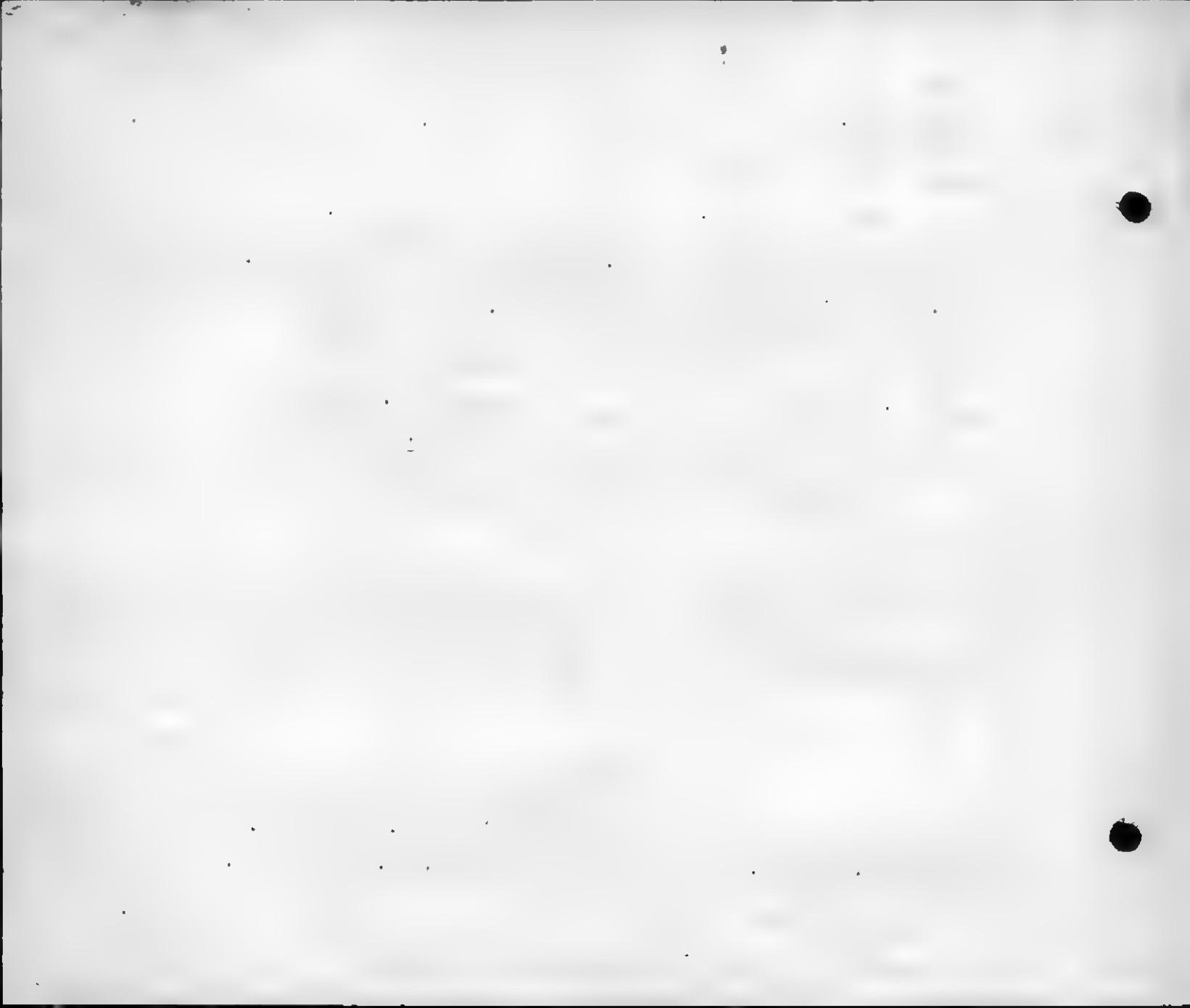
0434

## CERTIFICATE OF DEATH

Reg. Dist. No.

00429

1. PLACE OF DEATH a. COUNTY  Balto.		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville		c. LENGTH OF STAY IN lb 45 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pikesville				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 15 Waldron Ave.		d. STREET ADDRESS 15 Waldron Ave.		e. IS RESIDENCE ON A FARMS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Helen		First	Middle	Last	4. DATE OF DEATH Jan.	Month	Day	Year
5. SEX F.		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 27, 1900	9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John E. Mallonee				14. MOTHER'S MAIDEN NAME Gertrude A. Tarbert				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Michael Wladika		Address 15 Waldron Ave.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Hypertension		INTERVAL BETWEEN ONSET AND DEATH 6 months.		(c) 5415.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Reistown Rd. & Walker Ave.		(County) (State)
21. I certify that I attended the deceased from Sept. 1957, to Jan. 1960, that I last saw the deceased alive on Jan. 1960, and that death occurred at 5:22 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE Dr. James A. Miller PHYSICIAN'S NAME (Type) Dr. James A. Miller ADDRESS Reistown Rd. & Walker Ave. Pikesville 8								ADDRESS (Street, city or town, state) Reistown Rd. & Walker Ave. Pikesville 8 DATE SIGNED 1/22/60
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/21/60		22c. NAME OF CEMETERY OR CREMATORIUM Druid Ridge		22d. LOCATION (City, town, or county) Baltimore		(State) Md.
23. FUNERAL DIRECTOR'S SIGNATURE Loring Byers		ADDRESS 8728 Liberty Road		24a. REC'D BY REGISTRAR DAN 25 '60		24b. REGISTRAR'S SIGNATURE C. J. S. Tamm		



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0435

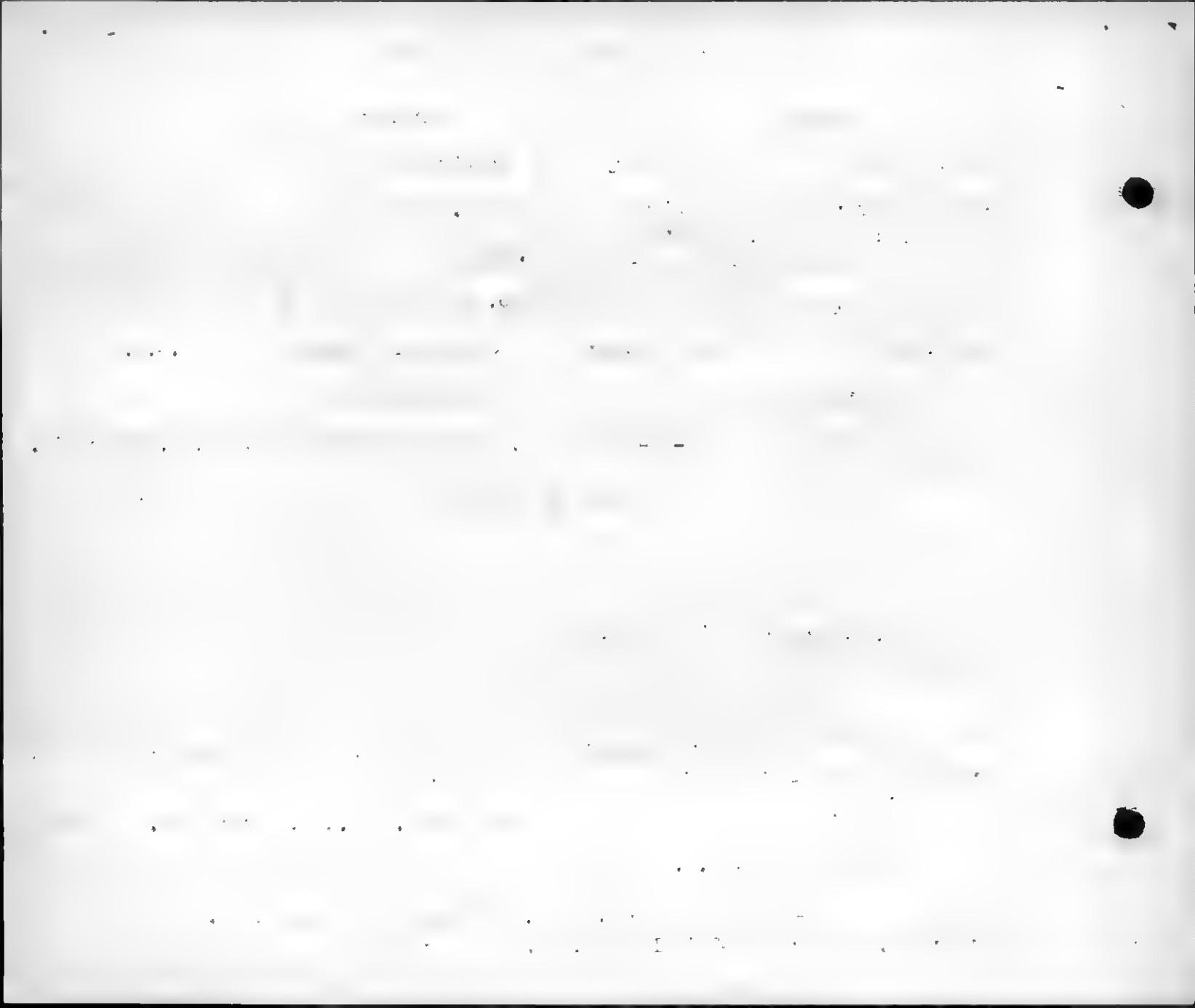
## CERTIFICATE OF DEATH

Reg. Dist. No.

00430

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by me funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Howard</b>		c. LENGTH OF STAY IN 1b <b>137 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED Also: WOOD and WOODWARD (Type or print) <b>Middle Wallace</b>		4. DATE OF DEATH <b>January 8 1960</b>	Month Day Year
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 15, 1895</b>
10a. USUA. OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Candy Maker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Candy Factory</b>	
10c. BIRTHPLACE (State or foreign country) <b>Stafford, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Woodard</b>		14. MOTHER'S MAIDEN NAME <b>Kate Woodard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>719-09-1285</b>	
		INFORMANT <b>Clin. Records VA Hospital BaltMd, Ft. Howard Div.</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>163X</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 YRS</b>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>VA</b>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>August 24, 1959, to January 8, 1960</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <b>Arlington Natl. Cemetery</b>
21. I certify that <b>VA</b> attended the deceased from <b>August 24, 1959, to January 8, 1960</b> , and that death occurred at <b>3:15 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>M.D. VAH Balt., Md., Ft. Howard Div.</b>	
ACTUAL SIGNATURE <b>Charles Allen, M.D.</b>		DATE SIGNED <b>1/9/60</b>	
PHYSICIAN'S NAME (Type) <b>CHARLES ALLEN, M.D.</b>			
22a. BUR. AL. CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/13/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Arlington Natl. Cemetery</b>	22d. LOCATION (City, town, or county) <b>Arlington, Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave.</b>	24a. REC'D BY REGISTRAR <b>JAN 11 '60</b>
			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Koenig</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

043C

## CERTIFICATE OF DEATH

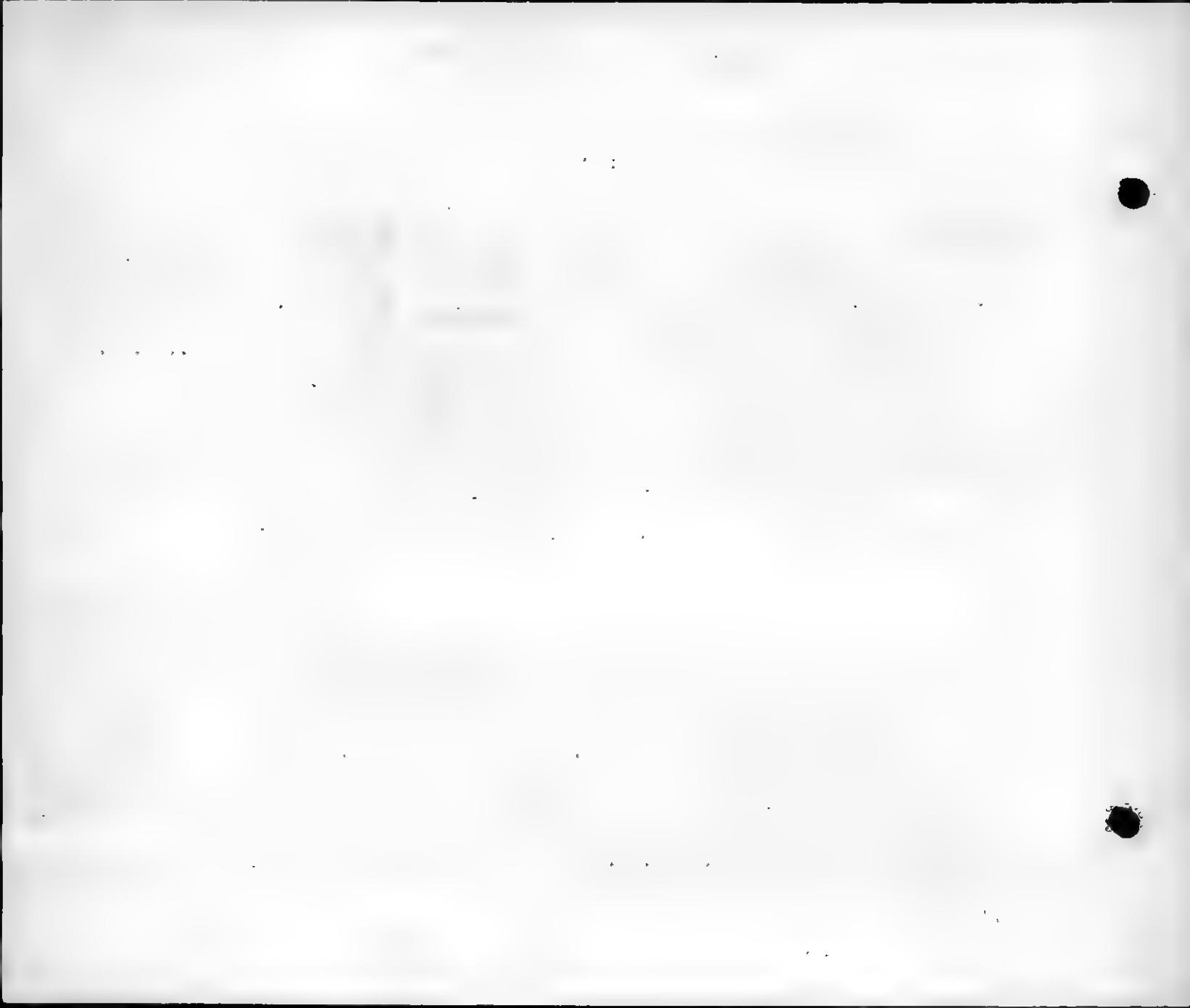
Reg. Dist. No.

00431

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Catonsville</b>		c. LENGTH OF STAY IN 1b <b>9mth29dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRING GROVE STATE HOSPITAL</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>	
d. STREET ADDRESS <b>701 Gorsuch Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Anna</b>	Middle <b>Margaret</b>	Last <b>Wooden</b>
4. DATE OF DEATH	Month <b>JAN. 1960</b>	Day <b>19</b>	Year <b>60</b>
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 17, 1881</b>
9. AGE (In years last birthday) <b>78 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife (Nurse- Ret'd)</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>William Weyraugh</b>	14. MOTHER'S MAIDEN NAME <b>Elizabeth Rehbein</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	16. SOCIAL SECURITY NO. <b>Unknown</b>	INFORMANT <b>Records: SPRING GROVE STATE HOSPITAL</b>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b>			
DUE TO Arteriosclerotic cardiovascular disease			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)			
DUE TO Generalized arteriosclerosis (c)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 19, 1960</b> , to <b>Jan. 20, 1960</b> that I last saw the deceased alive on <b>Jan. 20, 1960</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <b>SPRING GROVE STATE HOSPITAL</b>			
DATE SIGNED <b>1-20-60</b>			
ACTUAL SIGNATURE <i>Stella Wachsler</i>		M.D. <b>SPRING GROVE STATE HOSPITAL</b> 1-20-60	
PHYSICIAN'S NAME (Type) <b>Stella Wachsler, M. D.</b>		Catonsville 28, Maryland	
22a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1-22-60</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Baltimore Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Charles J. Krause</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

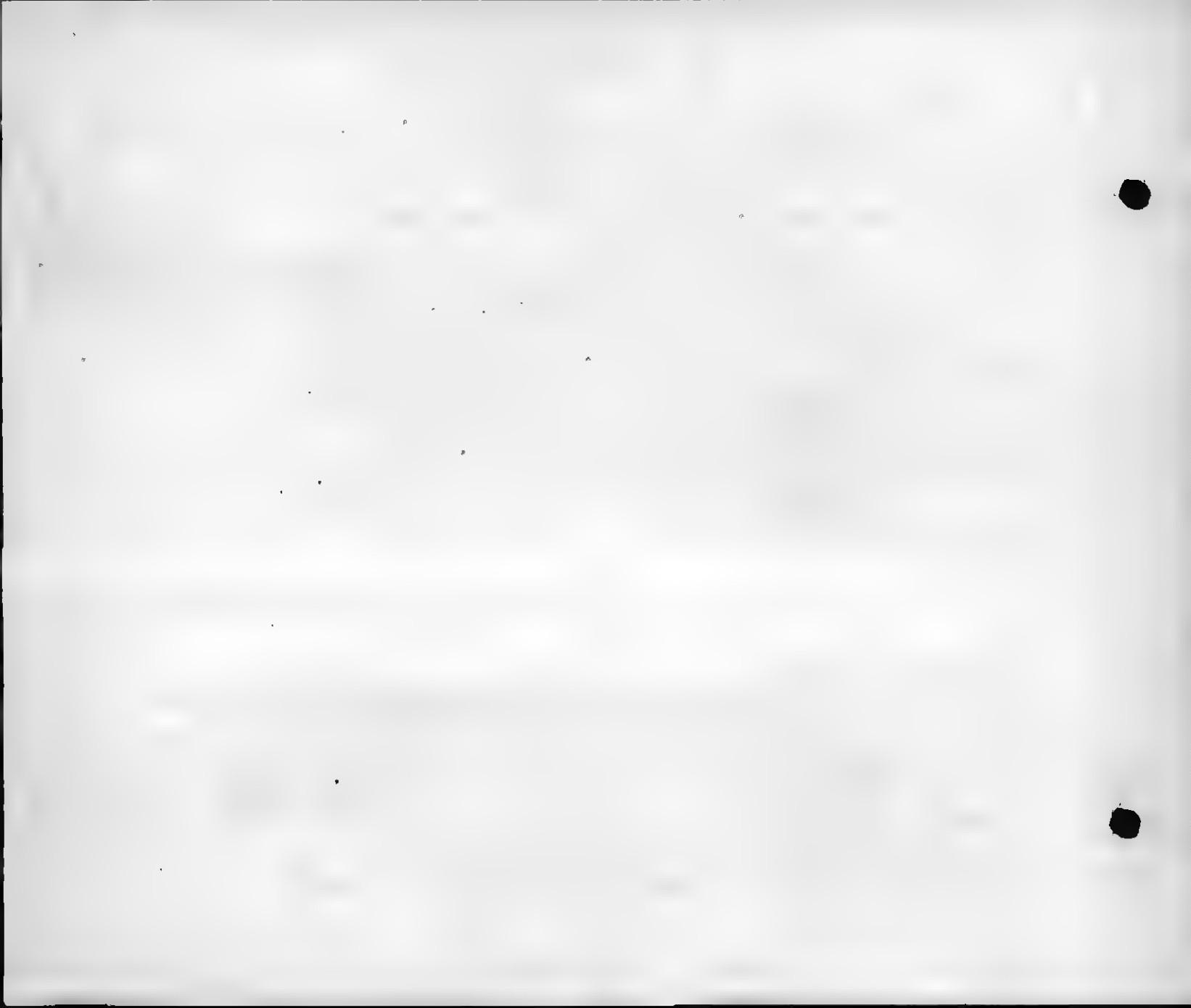
## 0228 CERTIFICATE OF DEATH

Reg. Dist. No. 00452

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Dundalk</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>53 Dundalk</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>818 S. 50th St.</b>		d. STREET ADDRESS <b>818 S. 50th St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JULIA</b>		First <b>THERESA</b>	Middle <b>WUNSCH.</b>
4. DATE OF DEATH <b>January 9 1960.</b>		Month <b>January</b>	Day <b>9</b>
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>March 29, 1884</b>		9. AGE (In years last birthday) <b>75 yrs</b>	10. IF UNDER 1 YEAR Months <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home.</b>	11. BIRTHPLACE (State or foreign country) <b>England</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jeremiah Hartnett</b>		14. MOTHER'S MAIDEN NAME <b>Hanora Sullivan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-----</b>	17. INFORMANT <b>John J. Wunsch</b>
Address <b>Same.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>260X</b> DUE TO <b>Diabetes Mellitus (Coma)</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1950</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <b>Arterio-Sclerosis</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1952</b>			
(c) <b>Hypertension</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>1945</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 9 1960</b> to <b>Jan 9 1960</b> , that I last saw the deceased alive on <b>Jan 9 1960</b> , and that death occurred at <b>4:55 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>MORRIS G. Jacobs</b>		ADDRESS (Street, city or town, state) <b>1010 NORTH PTY</b>	
PHYSICIAN'S NAME (Type) <b>MORRIS A. Jacobs</b>		DATE SIGNED <b>1/11/60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-13-60.</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>SACRED HEART CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>7401 GERMAN HILL RD. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles S. Geeler 901 S. CONKLING ST. BALTO, MD.</b>		24a. ADDRESS <b>ADDRESS</b>	
		24a. REC'D BY REGISTRAR <b>DATE JAN 14 '60</b>	
		24b. REGISTRAR'S SIGNATURE <b>C. Arthur S. Krause</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 0437 CERTIFICATE OF DEATH

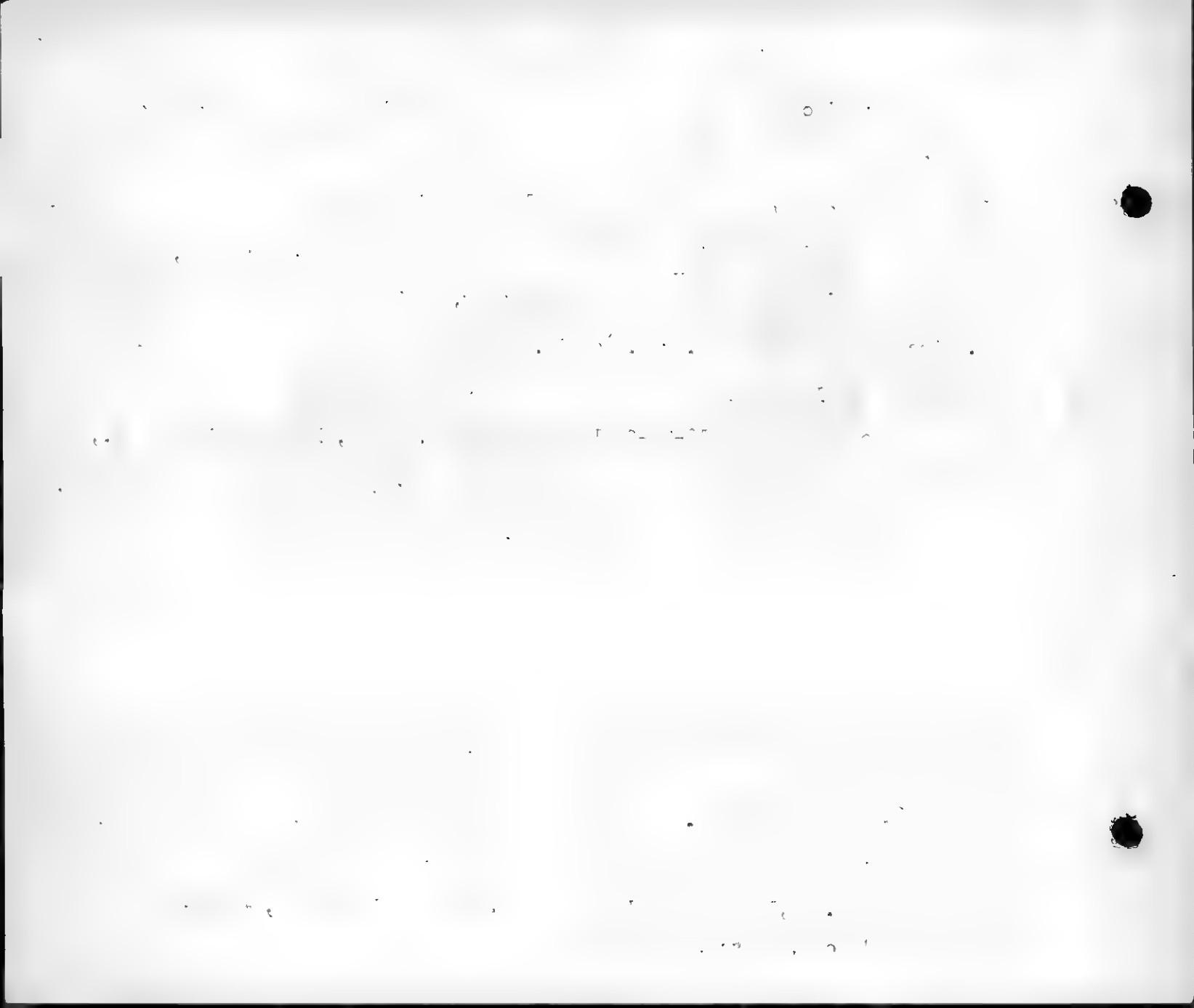
Reg. Dist. No.

00453

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>55 Towson</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>1624 Providence Road</b>		e. STREET ADDRESS <b>1624 Providence Road</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>CHARLES EDWARD YOUNG</b>		First <b>CHARLES</b>	Middle <b>EDWARD</b>
4. DATE OF DEATH <b>January 18,</b>	Month <b>January</b>	Day <b>18</b>	Year <b>1960</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 29, 1912</b>
9. AGE (In years lost birthday) <b>47 yrs</b>	10. KIND OF BUSINESS OR INDUSTRY <b>A. &amp; P. Tea Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Benjamin Charles Young</b>		14. MOTHER'S MAIDEN NAME <b>Mary Edna Sheppard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-3561</b>	INFORMANT <b>Catherine L. Young, 1624 Providence Rd., Towson</b>
17. INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Peripheral Vascular Disease</b> DUE TO (c) <b>Hypertension; cler. Nephritis; Thalotx</b>	
19. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <b>Tos. A. Sellack</b>		M.D. <b>200 W. Penna. Ave</b> <b>1/20/60</b>	
PHYSICIAN'S NAME (Type) <b>Tos. A. Sellack</b>		Towson, Md.	
22a. BURIAL, CREMATION OR REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Jan. 21, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Lorraine Park Cemetery</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Maryland</b> (State)
23. FUNERAL DIRECTOR'S SIGNATURE <b>John Burns' Sons, Towson, Maryland</b>		24a. REC'D BY REGISTRAR <b>JAN 21 '60</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Burns</b>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

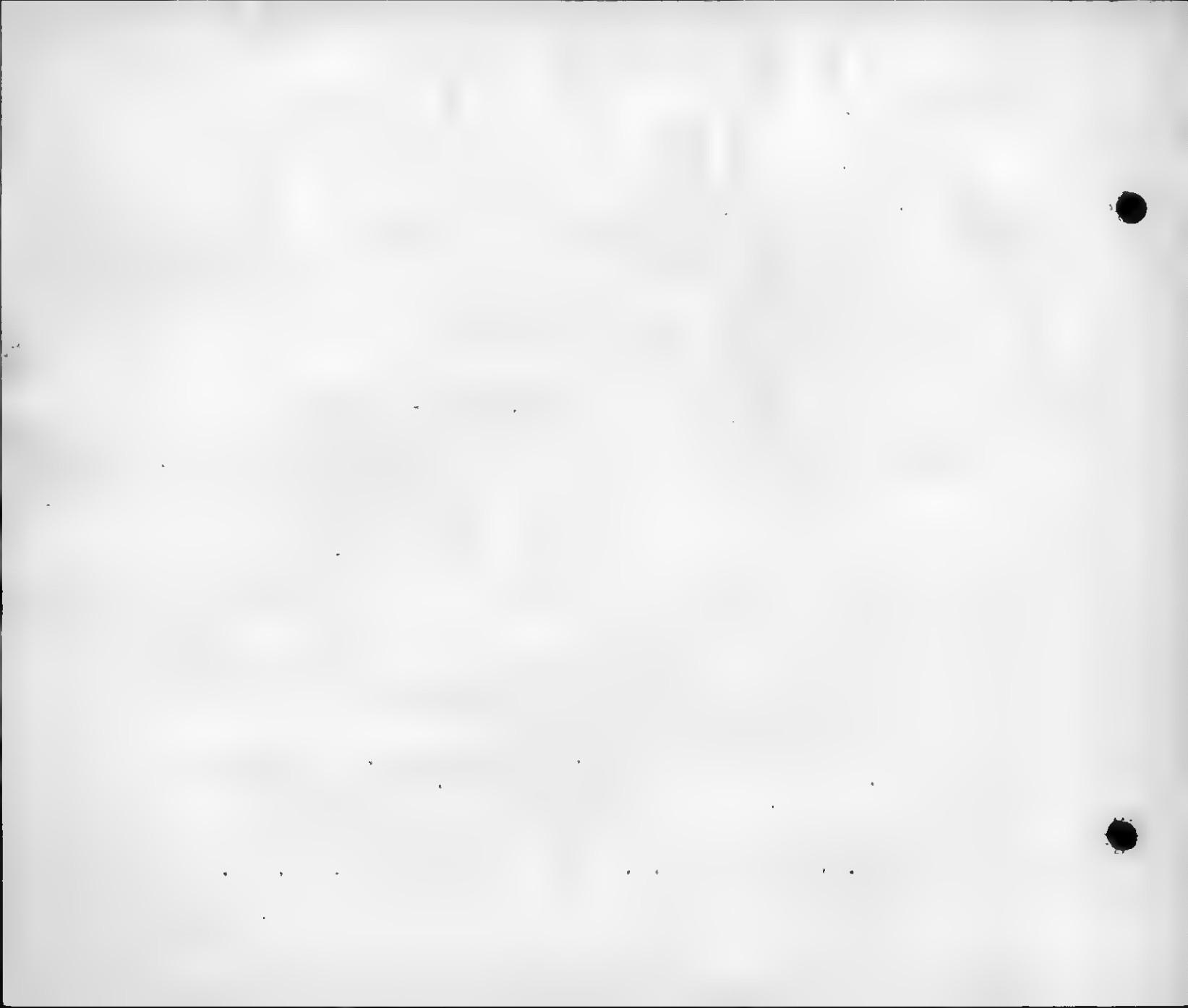
## CERTIFICATE OF DEATH

Reg. Dist. No. 00404

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <i>Md.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>		b. COUNTY <i>Baltimore</i>	
c. LENGTH OF STAY IN lb <i>64 Winter Ave</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Catonsville</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>64 Winter Ave</i>		d. STREET ADDRESS <i>64 Winter Ave.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John Wesley Young</i>		First	Middle
		Lost	4. DATE OF DEATH Month Day Year <i>Jan. 26 1960</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caf.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>	8. DATE OF BIRTH <i>June 22, 1910</i>
9. AGE (In years last birthday) <i>49 yrs.</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during time of working life, even if retired) <i>Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Ellicott City Md</i>	
11. BIRTHPLACE (State or foreign country) <i>Ellicott City Md</i>		12. CITIZEN OF WHAT COUNTRY <i>Ellicott City Md</i>	
13. FATHER'S NAME <i>Clarence Young</i>		14. MOTHER'S MAIDEN NAME <i>Emma Porter</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>16. Social Security No.</i>	
17. INFORMANT <i>Marie Young 64 Winters Ave.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive Arterio-sclerotic Heart Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <i>10 days</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <i>Jan. 26th 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>57 Winters Lane</i>	
20f. (City or town) <i>Catonsville, Md.</i>		(County) (State) <i>Catonsville Md.</i>	
21. I certify that I attended the deceased from Sept. 19th 1959, to Jan. 26th 1960, that I last saw the deceased alive on Jan. 26th 1960, and that death occurred at 6.30PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>E. F. Maloney M.D.</i> ADDRESS (Street, city or town, state) <i>57 Winters Lane</i> DATE SIGNED <i>1/26/60</i>			
22a. FUNERAL CREMATION? 22b. DATE THEREOF REMOVAL (Specify) <i>Burial Jan. 30, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>Western Star</i>	
22d. LOCATION (City, town, or county) <i>Catonsville Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Mrs. Katie R. Williams</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 1 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>
ADDRESS <i>322 Schroeder St</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page *1*  
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

0439

## CERTIFICATE OF DEATH

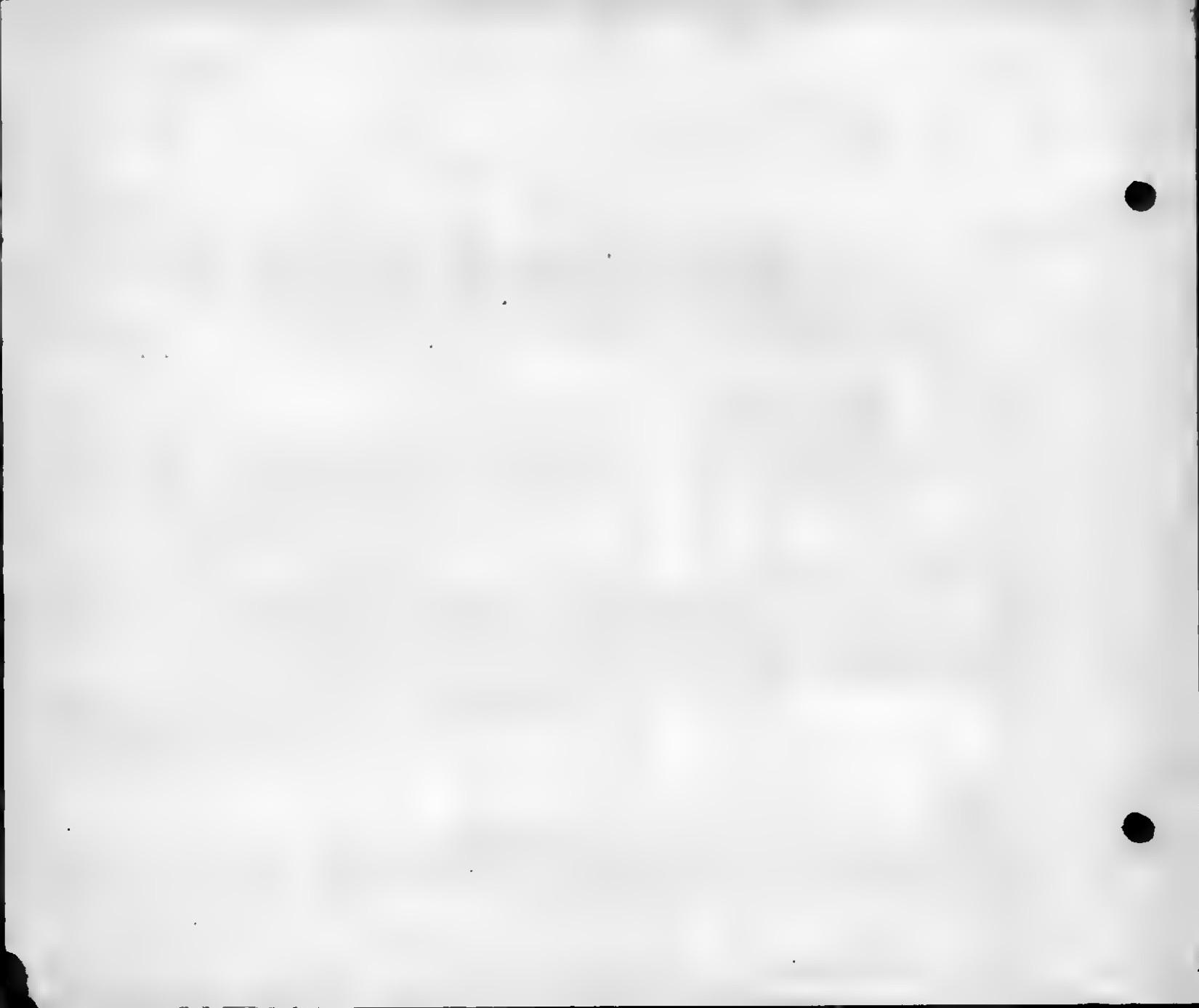
Reg. Dist. No.

00435

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b>		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE <b>Maryland</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>		b. COUNTY <b>Baltimore</b>	
c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>2500 Ambler Court</b>		d. STREET ADDRESS <b>2500 Ambler Court</b>	
3. NAME OF DECEASED (Type or print) <b>THOMAS</b>		First <b>F.</b>	Middle <b>ZEILER</b>
4. DATE OF DEATH <b>January</b>		Month <b>12</b>	Day Year <b>1960</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 3, 1921</b>
9. AGE (In years lost birthday) <b>38 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS Days <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Westinghouse</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>John Zeiler</b>		14. MOTHER'S MAIDEN NAME <b>Helen Bauer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW II</b>	17. INFORMANT Address <b>Mrs Agnes Zeiler 2500 Ambler Court</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-23-</b> , 19 <b>58</b> , to <b>1-12-</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1-12-60</b> , and that death occurred at <b>11:30 P.M.</b> , from the causes and on the date stated above. ACTUAL SIGNATURE <b>Eugene F. Nevy</b>		ADDRESS (Street, city or town, state) <b>M.D. 7001 Washington Rd</b> DATE SIGNED <b>1-14-60</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan 16, 1960</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Sacred Heart</b>
22d. LOCATION (City, town, or county) <b>Baltimore County, Maryland</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lilly &amp; Zeiler Inc.</b>		ADDRESS <b>1901 Eastern Avenue</b>	24a. REC'D BY REGISTRAR DATE JAN 15 '60
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Neve</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

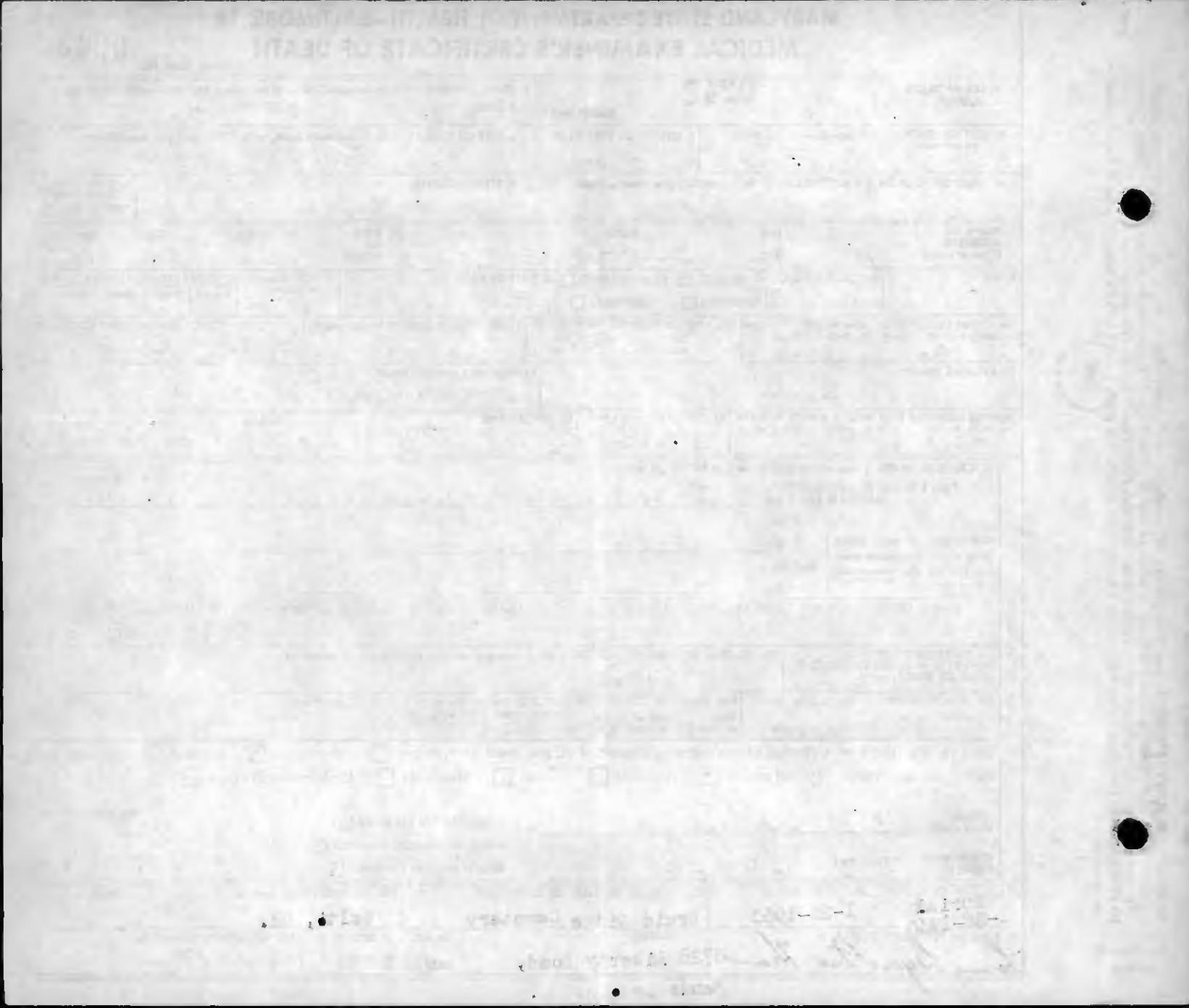
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist. No. **00436**

1. PLACE OF DEATH a. COUNTY <b>Baltimore</b> 0242 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reston Station</b> 5 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reston Station, Md.</b>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glen Falls Rd.</b>				d. STREET ADDRESS <b>Glen Falls Rd.</b>						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print) <b>MARTIN SHREEVE ZENTZ</b>		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb 2, 1892</b>	9. AGE (In years last birthday) <b>69 yrs.</b>		IF UNDER 1 YEAR	IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life—even if retired) <b>Contracting</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Builder</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co. Md. U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
13. FATHER'S NAME <b>David Grant. Zentz.</b>		14. MOTHER'S MAIDEN NAME <b>annabelle martin</b>								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>217-12-3576</b>		17. INFORMANT <b>Martha Zentz - Reston Station, Md.</b>		Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH								
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		5 min.								
420.1 DUE TO		Coronary Occlusion								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)										
(c)										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>None</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None.</b>								
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>None</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>		20f. (City or town) <b>Baltimore</b>		(County) <b>Md.</b>		
(State)										
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									DATE SIGNED <b>1-23-'60</b>	
ACTUAL SIGNATURE <b>D.D. Caples</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>								
EXAMINER'S NAME (Type) <b>D.D. CAPLES</b>										
22a. BURIAL, CREMATION, DATE THEREOF REMAINS (Specify) <b>Burial 1-26-1960</b>		22c. NAME OF CEMETERY OR CREMATORIAL DRUID RIDGE Cemetery		22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>						
(State)										
23. FUNERAL DIRECTOR'S SIGNATURE <b>Lenny Byers Fun. Home</b>		ADDRESS <b>8728 Liberty Road,</b>		24a. REC'D BY REGISTRAR <b>JAN 25 '60</b>						
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>						
VS. A15ME(S) SM 9/55										



1 X

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retyped by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, it may be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
0235						00457					
<b>1. PLACE OF DEATH</b> a. COUNTY <i>Balto.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Relay</i> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1531 S. Rolling Rd.</i>						<b>2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)</b> a. STATE <i>Md</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>51 Relay</i> d. STREET ADDRESS <i>1531 S. Rolling Rd.</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> First <i>HARRY</i> Middle <i>F.</i> Last <i>ZIEGENFUSS</i> (Type or print)						<b>4. DATE OF DEATH</b> Month <i>Jan</i> Day <i>6</i> Year <i>1960</i>					
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>12/23/1900</i>			9. AGE (In years last birthday) <i>59 yrs.</i>	IF UNDER 1 YEAR IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Greeting Card Wholesaler</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>Wholesale</i>			11. BIRTHPLACE (State or foreign country) <i>Pa.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>Milton Ziegenfuss</i>						14. MOTHER'S MAIDEN NAME <i>Sue Tully</i> <i>Marguerite Ziegenfuss</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> <small>(If yes, give year or dates of service)</small>						16. SOCIAL SECURITY NO. <i>4331</i> 17. INFORMANT <i>Paro &amp; Son, Toky Cards - cardiac fibrillation</i> <small>INTERVAL BETWEEN ONSET AND DEATH 72 hours -</small> <small>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</small> <small>(b) DUE TO</small> <small>(c) possibly pulmonary embolism few minutes</small>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: <small>IMMEDIATE CAUSE (a)</small> <small>4331</small> <small>DUE TO</small> <small>(b)</small> <small>(c)</small>											
<small>PARO &amp; SON, TOKY CARDS - CARDIAC FIBRILLATION</small> <small>INTERVAL BETWEEN ONSET AND DEATH 72 hours -</small> <small>Possibly pulmonary embolism few minutes</small>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Cuts</i>					
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>✓ 19</i> p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>1014 Francis Ave.</i>			20f. (City or town) <i>Balto.</i> (County) <i>Md</i> (State)		
21. I certify that (I) (this hospital) attended the deceased from _____ to _____, that (I) <input checked="" type="checkbox"/> last saw the deceased alive on _____, <i>Jan 5 1960</i> , and that death occurred at <i>1PM</i> , from the causes and on the date stated above.											
22a. SIGNATURE <i>Frederick J. Beiter</i> M.D.						22b. DATE SIGNED <i>Jan 6 1960</i>					
22c. PHYSICIAN'S NAME (Type) <i>FREDERICK J. BEITER</i>						22d. ADDRESS <i>1014 Francis Ave. - Balto 27 Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>1/9/60</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>London Park</i>			23d. LOCATION (City, town, or county) <i>Balto.</i> (State) <i>Md</i>		
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. McNaught &amp; Son</i> ADDRESS <i>28</i>						25a. REC'D BY REGISTRAR DATE <i>JAN 8 '60</i>			25b. REGISTRAR'S SIGNATURE <i>Orlando S. Kraus</i>		

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